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**An exploration of the articulation of African traditional medicine and Western  
biomedicine in hospital spaces in the town of Barberton, South Africa**

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A thesis submitted in fulfilment of Doctorate in Philosophy at  
the University of Edinburgh,  
presented in the year 2014

## Declaration

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done mainly or wholly while in candidature for a research degree at the University of Edinburgh.
2. This the work has not been submitted for any other degree or professional qualification.
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;

Signed:

A handwritten signature in blue ink, appearing to read 'P. Andreadis', with a long horizontal flourish underneath.

Petros Isidoros Andreadis

Date:

27 November 2013

## Acknowledgements

I would like thank everyone who took the time to participate in this study. Of these participants are a number of tuberculosis patients who were kind enough to narrate their personal journey's through a complex therapeutic landscape. Sadly, some of these people are no longer with us, and I am encumbered with the knowledge that our discussions were likely the last time they told their personal stories in any detail. It has been incredibly challenging to read, and re-read the words of those who departed this world in such a painful manner, not surrounded by family or loved ones, but instead ensconced in a community of sufferers.

Of those who placed my feet on the academic path so many years ago, and those who have encouraged me along since, a handful deserve particular acknowledgement. Sian Pierce, an excellent and model teacher who first introduced me to methods and methodology, and Lynn Hodgkinson whose perennially positive disposition and words of encouragement gave me the confidence to take the next steps following my undergraduate degree. Bianca Ambrose-Oji who introduced me to researching the practical side of a world beyond the positivist realm, and Robert Thornton who introduced me to the town of Barberton, and without whom this project could never have happened.

A particular acknowledgement must go to my two primary supervisors, Prof Sarah Cunningham-Burley, who has gone well beyond her remit to be incredibly patient and supportive throughout this process, and Dr Rebecca Marsland, who has guided, and periodically dragged a sometimes intractable, often confused student to the many signposts that litter the landscape where anthropology collides with public health and medicine. I am indebted to them both, and wish to stipulate now that any inconsistencies or glaring omissions in this thesis, are in no way a reflection on them.

All of the above have been extraordinary mentors. They have all, in one way or another, made their mark on the world. Some with their devotion to their academic fields of study, some because they are incredible teachers, and some with their deep and considered attention to the welfare of students and scholars. Through them, I have learnt a great deal about myself, and they have all, in their own way, shaped who I am, and how I approach my work.

A thanks to friends along the way, Heide Weishaar, Marketa Keller, Nazir Lone, and Sandalia Genus, who have provided advice, emotional support, and often even a place to stay whilst this thesis came together!

My final words are reserved for my family.

Aged seventeen I decided to quit a degree in mechanical engineering only a year into the course. Over the next three years, which saw me depart my family and home shores to go and ‘find myself’ abroad, my father would periodically enquire as to when I would return to studying. Fast forward eight years, and the last conversation I had with my father was on an impromptu overseas call I made to South Africa whilst strolling through Bristo Square that lies in the shadow of Edinburgh University’s imposing McEwan Hall. In this final conversation I mentioned that I had just then left a meeting in which I had been awarded a scholarship to continue my studies for this doctoral thesis. Only a few weeks later my father passed away after many years of suffering with emphysema, the terrible gift from a lifetime of cigarette addiction. That our final words relate directly to this project evokes a juxtaposition of bittersweet emotions - a tug of war between contentment and melancholia.

To my immediate family this work represents many years of both physical and emotional distance and I am certain that it’s conclusion is most welcome. A thanks too to my extended family in South Africa who over the years of research in my country of birth have both put me up, and put up with me while I have toiled away at this project. I should also take the time to acknowledge my new family who have yet to truly encounter me when I am not a ball of nervous tension.

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Petros Isidoros Andreadis

## ***Abstract***

Whilst hospitals are the dominant institutions through which Western biomedical treatment is delivered, it is also argued that these institutions do not reproduce a distinct notion of a biomedical model, but instead assume different configurations, reflecting and replicating wider socio-cultural processes. In South Africa, this includes a reflection and replication of challenges arising from an eclectic therapeutic landscape in which biomedicine is but one avenue.

The challenge presented is that South Africa's dominant therapeutic cultures of African traditional medicine, said to be used by an estimated 80% of the population, and Western biomedicine, reflect two distinct, and arguably conflicting, ontological and epistemological paradigms. A recognition of this is encompassed in many hospital ethnographies exploring how biomedical professionals confront and manage the collision of these therapeutic systems within the institutional space. Whilst such studies have been carried out in a number of African country-settings, this interface of therapeutic cultures in South African hospitals has received scant attention.

Using a range of interpretive research methods that include narrative, informant, and respondent interviews, this project, carried out within two public hospitals in the town of Barberton, South Africa, explores the views, experiences, and perspectives of hospital-based biomedical professionals, and hospital-bound tuberculosis patients, on the articulation of African traditional medicine and Western biomedicine.

### ***Barberton tuberculosis hospital***

Using a narrative approach, an exploration of TB patient's stories of navigating the plural therapeutic landscape is undertaken. These examine the complex navigation of a plural medical ecology, the conflict arising as a result, as well as how personal accounts reflect broader meta-narrative illness archetypes. Alongside this, is an examination of the conflict between nurses and patients within the hospital-confines that arises as a result of the interface between African traditional medicine and Western biomedicine. This is examined in the context of a TB treatment facility that reflects strong Foucaultian characteristics of institutional control, and observation of patient bodies and behaviours.

### ***Barberton general hospital***

Using informant and respondent interviews, an exploration of the positioning, views, and sometimes allegiances of nurses and doctors towards African traditional medicine and Western biomedicine, is undertaken. This includes an examination of the described articulation between these therapeutic cultures within the biomedical space. A particular emphasis is placed on examining the role of nurses as brokers of culture, as they mediate and broker conflict arising as these therapeutic systems collide.

This study presents a complex milieu of views and positions regarding the interface between African traditional medicine and Western biomedicine. Tuberculosis patients portray convoluted and meandering health seeking journey's between healing systems, and both nurses and tuberculosis patients, describe an institution attempting to position itself as distinctly biomedical. Whilst African traditional medicine does emerge within this hospital space, this is largely clandestine, and is actively discouraged by biomedical staff through vigilant observation and oversight that is interpreted by patients as overt, and excessive biomedical control.

In the general hospital, nurses and doctors described how African traditional medicine is encountered and confronted, where it is largely viewed as clouding and complicating biomedical healing and treatment endeavours. The range of views on these ontologically distinct systems, are broad, where health professionals who reject traditional medicine, and those, mainly nurses, who use traditional medicines, work side-by-side – sometimes leading to internal conflict.

An exploration of the role of nurses as culture brokers is complex, where nurses describe encountering significant conflict in mediating between patients expectations, expectations demanded by professional roles, and their cultural allegiances. This is embedded within a complex political landscape, where biomedical practitioners who position themselves against African traditional medicine, feel reluctant to voice concerns in a post-apartheid institution that prioritises cultural pluralism, and respect for personal beliefs.

This project uncovers the conflict and tensions arising from the plural medical landscape within, and without Barberton's hospitals, as well as how the stance towards therapeutic pluralism by biomedical professionals differs between these institutions depending on context.

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## *A Note on Names and Quotations*

Due to the sensitive nature of the topic, many participants would only consent to interviews and discussion on the provision that they remained entirely anonymous. As such, I have altered names, professional role, and sometimes the sex of respondents and informants to ensure these identities are protected.

The following are a few quotation conventions used in the thesis:

- ❖ Words that are in **bold** denote a speaker's own emphasis.
- ❖ The use of [square brackets] enclosing words are:
  - Points of clarifications and explanation.
  - Words that 'fill in the gaps' – i.e. words that were implied, but often not verbalised during interviews.
  - Observations that would be lost during plain-text reading.
  - A description of non-verbal cues and gesticulations.

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## *Foreword*

I was born in South Africa in May 1980, where up until the age of nineteen, my life was almost evenly divided between the coastal cities of Port Elizabeth in the Eastern Cape province, and Durban on the sub-tropical east coast. I spent these formative years living in enclaves of middle-class White suburbia, and as a result, any glimpses of rural South Africa were largely restricted to my observations through the dust-coated window of a burgundy Toyota Cressida as we travelled the 2400 kilometre round-trip between Durban and Port Elizabeth.

I was five years old on our first trip, fifteen on the last, and looming large in my memories, apart from crooning along with the crackled voice of Nana Mouskouri emanating from a too-often played cassette tape, was our meanderings through landscapes that were a stark contrast to my privileged sub-urban life of back-garden swimming pools and white picket fences. These trips brought me face-to-face with an altogether foreign world of sweeping undulating veld and craggy mountain passes. Huddled in the back seat of our car, I was propelled across the surface of this broad shifting landscape, where my vision, unimpeded by urban sprawl, would beckon my childhood imagination to soar unfettered.

I can still recall being squeezed in the back seat beside my two older brothers, the smell of cold boiled chicken and hard boiled eggs diffusing throughout the car from a kit-bag heavily laden with *padkos*<sup>1</sup>. And it would be impossible to forget the bright orange and white barrel-shaped ‘cooler’ dispensing lukewarm water that left a lingering plastic aftertaste.

Our route on these cross-country pilgrimages usually took us through what was then known as the Ciskei and Transkei *Bantustans*<sup>2</sup>, as well as the landlocked mountain kingdom of Lesotho, and the interstitial spaces spanning cities and towns along the route were dotted with rural Xhosa, Sotho, and Zulu settlements and homesteads. For a child, these spaces held an intrinsic mysterious property of the ‘other’, the seemingly innumerable settlements representing a very different way of life and living to my own.

From my observation-post behind that dusty window I would observe the thousands upon thousands of small houses rushing past me. They clung to grey rocky slopes, floated in lush green fields, and squatted in red ochre-rich soils, and were usually loosely connected to the asphalt highway by long umbilical footpaths that disappeared in and out of tall dry grass and

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1 Slang derived from Afrikaans, literally ‘road-food’: Referring to travel supplies, but also a macabre reference to any animal that has an unfortunate and ill-timed encounter with a fast-moving vehicle.

2 Semi-autonomous Black homelands established by the apartheid government.

thorny scrub. These distant houses, usually white-washed, but often painted in pastel-blues, pinks, and greens, stood in vivid contrast to their surroundings. Colourful baubles emerging from undulating plains, or clinging tight to earth and rock. Of the lives and livelihoods of these rural residents I could imagine little. The only fact to hand for a child was the colour of their dark skin - a stark juxtaposition to their many-coloured houses.

The apartheid machine had done its job effectively. Up until the age of twelve I went to school in the exclusive company of middle-class whites, raised in an environment that in no way reflected South Africa's cultural diversity. Black culture largely remained visible on the fringes of my social horizon, rendering life a paradox of being constantly reminded of, while at the same time being entirely denied the opportunity to fully explore the encircling diversity. This is not to suggest that considerations of ethnicity and cultural diversity were entirely absent from my own familial circle. Indeed, my Greek family and community went out of their way to ensure I was fully cognizant of what it meant to be Greek. I learnt to recite the Greek national anthem long before understanding what the words meant, and I was frequently reminded of my antecedents' enduring contributions to Western thought and culture. And every Greek independence day I would be compelled to parade around our small community in a *tsolia*, Greek national dress worn by men, and boys, that consists of a frilly white kilt, blue-silver waistcoat, thick white hose, tasselled garters, and bright red shoes adorned with large pom-poms. And to top it all off, a bright red cap with a flowing black tassel<sup>3</sup>. My role on each these occasions was to stand trembling in front of the entire Greek community, reciting barely understood nationalist poetry to the assembled smiles of the older generation who sat ensconced in the warm glow of transposed culture.

My early years were a complex struggle to balance my own South African / Greek identity and heritage and the introduction of those fleeting glances of a rural world-apart served to add to this confusion. The critical appraisal of different creeds, cultures, and religions, were restricted to the bounded realities of myself and my class mates, all of us derivatives of Western European ancestry, with indigenous African culture almost relegated to the periphery of my social horizons.

As a child I had been living in relative ignorance of apartheid, or rather I was too young and hermetically sealed to fully grasp the festering rot at the heart of the surrounding engineered society. Indeed, even on those long and winding trips, I felt as if I was moving in a bubble through a foreign world that was trying to press itself in through the dust-obscured windows.

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3 How many times I wished those red shoes had been magical, and that three heel-taps would instantly transport me home. This would admittedly do me little good as my home at this point was my grandmothers house which lay only a stones-throw away from the Greek church and community hall. Escape was futile.

Sadly, until the dissolution of apartheid and the subsequent de-segregation of schools when I was 12, my encounters with Black Africans was limited to the ‘help’ in my Grandmothers household.

In common with many White children of that era, Blacks were largely known to me as people who did the cleaning and labouring, toiling as gardeners, maids, nannies, and cooks. They were, and indeed often still are, patronisingly referred to as ‘girls’ and ‘boys’, and like children they were expected to be seen, and not heard.

My early childhood was surrounded by the ‘help’, ghosts dressed in shell-suit overalls and drab pastel uniforms<sup>4</sup> floating in and around my grandmother’s house by day, and disappearing with the night. heavy-shouldered Joyce lived much of her life in the spartan confines of the purpose-built servants quarters that adjoined the house, and Samson, the garden ‘boy’ of titanic proportions, lived in the ‘Location’ – the colloquial term given to black settlements that to this day lie on the margins of South Africa’s towns and cities.

Joyce was a constant presence in my grandmothers household and I recall wandering into the expansive kitchen one day, to see if I could slyly negotiate something from the fridge. Joyce glanced at me conspiratorially, turned back to the large watermelon my grandmother had tasked her with carving up, and tentatively spoke the words: *θες καρπουζι*<sup>5</sup>

I was probably around six or seven at the time and I recall being rooted to the floor as my brain tried to deal with this anomaly. How did Joyce know Greek?! She spoke English fluently, albeit with a heavy accent. And I was always mesmerised by the cliquing of the Xhosa language whenever she would sing a rendition of Miriam Makeba’s famous song *Qongqothwane*, widely referred to as the ‘click’ song - probably because most Whites cannot pronounce its proper name. But Greek?

I learned, but did not fully appreciate till much later, that Joyce’s life had been a peripatetic journey within the few square miles of Port Elizabeth’s Mill Park and Parson’s Hill suburbs, the area abutting the Greek Orthodox church around which the bulk of my immediate community orbited. Joyce was not just a ‘girl’, but she was a ‘good girl’ who was passed around the Greek community like a prized possession. She might eat a lot of sugar, as I heard my grandmother complain on many occasion, but she wouldn’t steal the spoons.

I must confess that reflecting on Joyce’s life does sadden me. As a child I gave little consideration to her, nor appreciated how she contributed to the running of the household.

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4 Those drab pastel uniforms remain as standard even today.

5 Phonetically: *Thes karpouzi*? Greek for ‘do you want some watermelon?’

She was there in the evenings while helping to prepare dinner, and floated around in the mornings while I was being socked-and-gartered, blazered, tied, and capped for school. I had no conceivable idea of how apartheid had dictated Joyce's movements and freedom, nor that until I was six years old, she was legally obliged to carry around a *dompas*, an 'internal passport' complete with fingerprints and photograph where it was recorded that she was an employee of Cleopatra Demas, and therefore permitted to be present and to freely navigate within our White suburb.<sup>6</sup>

Long after reflecting on Joyce's role in my life, and long after I had penned the preceding paragraphs, I chanced upon Georgina Horrell's writings on 'White' confessions in South Africa. She observes that a common feature of 'White' confessional narrative reflections is that they are filtered through the 'rose-tinted' eyes of 'innocent' childhood-selves, where the figure of the Black maid, often assumes the position as a "*cipher for perceived and acknowledged injustice but also a source of privileged information, a "native informant" who contributes significantly to the white child's political awareness* (Horrell, 2009 p 59). Joyce's attempts to contribute to my own political awareness might have been subtle, but they were undeniably present, and it is to my enduring dismay that I will never be able to repay her.

Of schooling, the apartheid-informed syllabus would quietly side-step discussion of our (dis)ordered society, and, to its Whites-only charge, would emphasise a decidedly Eurocentric narrative of South African history. We were inculcated with tales of Vasco de Gama's rounding of Cape Horn; our Dutch 'founding father' Jan van Riebeeck - onetime governor of the cape colony whose head apparently adorned the banknotes of my youth<sup>7</sup>; and the colonial expansionist efforts of Cecil John Rhodes. Add to this French Huguenots fleeing religious persecution; hardy and heroic *Voortrekkers* of Dutch descent migrating away from the British controlled Cape colonies to establish their own independent republics; and of course the Anglo-Boer war.

I can still vividly recall my childhood spent in the halls and courtyards of Port Elizabeth's Grey Junior School – a bastion of British colonial heritage and privilege. On frequent school outings we would be ferried around the city's colonial monuments and museums and encouraged, or rather compelled, to connect an indistinct colonial past with the hard and tactile physicality of the present. This is not to say that we didn't learn about Bushmen,

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6 Failure to carry this *dompas* could lead to arrest and imprisonment.

7 In an amusing twist of fate, the portrait that most South Africans would identify as Jan Van Riebeeck, whose face had for decades adorned the country's currency, is in fact the portrait of a contemporary Dutchman named Bartholomeus Vermyden. (Gilomee and Mbenga, 2007).

Hottentots, the Anglo-Zulu war or the brutality of Shaka Zulu and his backstabbing sibling Dingane, but rather Black history and culture was something upon which little critical emphasis was placed. White historical figures were cultured, god-fearing, adventurous, pioneering, civilized, advanced, tenacious, while Black contemporaries, when they absolutely had to be part of the settler narrative, were uncultured, savage, morally deviant, pagan, brutal, and deceitful, and of course culturally and intellectually inferior. These differences were both explicitly and subtly woven into my childhood upbringing with lessons reinforced by the surrounding social and cultural hierarchies.

I only came to realise many years later the challenges of the second-class existence forced upon South Africa's indigenous people, and indeed others of 'darker' skin tone, and on reflection it is now easy to recognise that by pure accident of birth, my first steps in life were taken on a painstakingly engineered glass floor that had been placed under my feet.

I cannot pinpoint exactly when the apartheid system started to show the first cracks that heralded its eventual disintegration, however, it was quite evident to me that our cross-country trips between Durban and Port Elizabeth coincided with apartheid's panicking death throes. Indeed, I recall very clearly how my father would equip himself with his blocky revolver when embarking on these trips. This coincidence of political instability, coupled with my fleeting window into an altogether foreign world, spurred my nascent and growing recognition of the discordant threads weaving and contorting through the country's social fabric.

It was around the year 1990, when I was ten, that an organisation called the African National Congress, whose green, yellow, and black motif consisting of a shield, assegai, and clenched fist, started filtering into my consciousness. Most likely because this motif was featured on every evening news bulletin of the day. I used to sit watching the news with my uncle who, probably forgetting I was in the room, would spit epithets at the television news whenever an ANC story featured. "*They'll kill us in our beds.*" I used to hear him mutter regularly. '*Them*', of course, being '*the Blacks*'.

I learned only much later that he was a survivor of the Belgian Congo independence movement, and had only escaped the country with his life because of the kindness of the Black workers on his lost coffee plantation. His bitterness at losing all his possessions, had left him penniless and homeless, and reliant on the kindness of his sister, my maternal grandmother. And indeed, being saved by his 'servants' he thought lower than himself, likely fuelled the rancour and bitterness in his waning years. His personal experiences served



to fuel his consistent mutterings that the demise of apartheid, and the weakening of the state hand, would only lead to a wave of Black retribution.

Admittedly, I was a little on the young side to be politically conscious, and indeed in my Whites-only school the primary concern amongst my peers was the kudos one could garner in a frenetic and highly competitive marble season. Nonetheless, the gravity of the moment had not entirely escaped us children as the political rumblings that fomented fear and unease around many white middle-class dinner tables had trickled down into the playground.

I distinctly recall Mr Gibson addressing my class of ten and eleven years olds one afternoon, probing our opinions on the possibility of Blacks and Whites attending school side-by-side. And I can still recall the names of my peers who openly balked at the idea. One was quietly rebuked by our liberal-leaning teacher for using the word *kaffer* when expressing his, or more accurately his parent's, opinions<sup>8</sup>.

I now realise that I was living in a time, and in a community, gripped by widespread anxieties and concerns brought on by the fear that the relinquishing of White state-control would result in a tidal wave of retribution by the county's oppressed Black majority. These fears were captured in the prevailing apartheid meme of *die swart gevaar*<sup>9</sup> – Afrikaans for *the black peril*.

Whilst I was unable to fully grasp the complex political ructions of the time, I was nonetheless sensitive to the fears and anxieties of those around me. And I suspect that the sudden appearance of packets of candles and canned goods in my grandmother's kitchen had something to do with the rumours of *die swart gevaar* circulating around our small Greek community. However, following the thankful demise of apartheid, there was of course no 'Black tidal-wave' of retribution, no '*swart gevaar*', but instead, in the wake of these imagined fears, a fragile hope spanning a gnawing chasm of shame.

Desegregation was rapid following Mandela's release from prison, and aged twelve I began high school in the city of Durban in a multi-hued congregation. For the first time Black children attended schools once entirely out of reach, and their parents slowly began moving

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8 *Kaffer*, an epithet that holds similar connotations to the racial slur, *nigger*, is arguably the most racially charged label one can use in South Africa. A derogatory term used to refer to Blacks, it has Arabic origins, meaning *unbeliever* or *one who conceals*. On reflection, I can only imagine what Mr. Gibson must have thought when he heard the word used by a ten year old child. Indeed the word holds such strong connotations of illegitimate and oppressive power that I long debated with myself on whether I should use it in full in this project, and indeed in earlier drafts used the common phrase - '*the k word*' instead.

9 The notion of *die swart gevaar* alludes to the threat of political instability arising from a neo-Malthusian paradigm of exponential Black population growth outstripping White population growth. Brown (1987) provides an excellent, and disturbing, analysis of the apartheid government's disturbing attempts to control the size of the black population through disguised 'family planning' measures.

into areas once designated the exclusive domain of Whites. The landscape of White suburbia was irrevocably changed. The compartmentalised pluralism of the old South Africa had slowly started to dissolve and I was fortunate enough to spend my high school years in this new South Africa, and be part of the first waves of post-apartheid learners to sit side-by-side.

Like myself my Black friends had quickly developed what is widely referred to in South Africa as a *model-C* accent, and if one were to close their eyes and hear us speak it would be a challenge to define our races by any spoken inflection.<sup>10</sup>

However, while the welcome friendships I developed across the spectrum of South Africa's races and creeds in my five years of high school opened my eyes to rich and diverse thought, belief, and culture, it was quite evident that despite our diversity my peers were all drawn from roughly the same social stratum – children of urban middle-class professionals.

While I learnt a great deal about the urban Black middle classes from school friends, I learnt almost nothing of Black rural life given that my friends knew about as much of rural South Africa as I did. As a result, those spaces that span South Africa's cities that feature so large in my childhood memories, and the people therein, would remain at the very margins of my consciousness for a time yet.

Aged nineteen, I left South Africa for the shores of the United Kingdom and returned seven years later to conduct fieldwork for an MSc in rural development. Locating myself in the rolling hills and mountains of KwaZulu Natal province, I set out to explore the relationship between HIV and natural resource use amongst rural dwellers who were heavily reliant on the forests and natural water sources for the most basic survival. On reflection, I am now reasonably sure that at least part of my reason for pursuing this academic avenue stemmed from a desire to fill in some of the gaps from my youth and explore the South Africa that resided on the fringes of my memory, the world lying just beyond that dusty car window.

Rural life deep in the rolling hills of KwaZulu Natal appeared to be a complex amalgamation of modern and traditional, a culture and way of living that was fleetingly familiar, but at the same time entirely alien, and bearing no resemblance whatsoever to the suburban landscapes of my youth. There was, of course, a thin veneer of familiarity and shared understanding. For

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10 Model-C refers to South African schools that are in effect semi-private institutions, most with long established and colonial histories. During apartheid, they catered exclusively to children of the White middle class. Being Black, and being classified as having a *model-C* accent - i.e. without the trace of an '*African*' accent - is to display one's education and membership of the privileged Black middle classes that were able to re-position themselves after apartheid. This phrase can and has been used in a derogatory manner. The terms *coconut* and *Oreo* have now emerged in South African parlance to describe Blacks who affect this *model-C* accent. The terms cast an aspersion on a Black person's cultural authenticity by accusing them of being Black on the outside but White on the inside. See (Mckinney, 2007; Rudwick, 2008))

example, I understood a good deal of local nuance and slang and the many gestures and expression that are uniquely South African. Nonetheless, I could not escape the feeling of being dislocated in my own country. By undertaking this research I was in fact critically interrogating my own South African identity.<sup>11</sup> Despite these challenges I persevered with my project and was drawn into the kaleidoscope of rural Zulu life that was a blend of both modern and traditional.

The rural homesteads in the mountains and hills of KwaZulu Natal sat in gardens of various sizes, and were allotted and managed by the local Chief and his various Induna (headmen). Single-room rondavels were constructed using an eclectic mix of materials from modern cinder blocks and rough two-by-fours, to homemade mud bricks and twisted and knotted tree branches. Chimneyless-roofs were built either of tin panels upon which the rain would beat staccato tattoos, or traditional thatched reed whose inner stems would over time become heavily matted with the grease and grime rising from the central cooking pit sunk into the centre of hard-pack floors.<sup>12</sup>

Most homesteads struggled to survive on a combination of government social grants and remittances from urban based family members, and while almost all households practised limited subsistence farming this was always just a meagre supplement to household caloric needs. Even if families had wanted to increase agricultural output the absence of an irrigation infrastructure rendered this impossible. As it was, depending on proximity to boreholes or natural water sources, households would usually spend a number of hours every day collecting water for the essentials of drinking, cooking, and hygiene. Furthermore, households had to face the daily challenge of evading roving patrols of ‘forest-police’ while collecting firewood from the privately owned commercial forests.<sup>13</sup>

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11 By undertaking fieldwork in South Africa, I had to confront rising internal tensions of the authenticity of my own South African identity. Partly because I had been in the UK for an extended period of time, partly because this was a perennial issue of consideration given my dual South African / Greek heritage, and partly because I was embedded in this alien rural world where I – as a young white man who was clearly a recipient of a privileged middle-class legacy – was now studying the *poor black native*. Furthermore, I was a South African who had had the means and wherewithal to escape the challenges facing a country developing in fits and starts, and I could not fully shake the feelings that I was viewed as someone who had abandoned their native land.

12 Holding most of my interviews indoors, the hanging smoke would cause my eyes to sting and water profusely, and this was always a source of much amusement to those I was visiting.

13 Forest-police were contract security who would patrol the privately owned forest. Many people could not afford the ‘firewood-license’ issues by the large commercial forest owners, and these private security contractors would act as a deterrence, supposedly handing over unlicensed trespassers to local official police or, depending on who was caught, do something far worse. I learnt from the local populace that rape was not unusual in this respect.

Most homesteads had at least one battery operated radio, and, despite the deep and widespread poverty, most households also had a mobile phone.<sup>14</sup> With no energy infrastructure phones had to be charged in the town requiring a twenty kilometre return hike over rugged hills, or if one could afford the twenty rand (approximately £2 at the time), for a tumbrilling taxi ride over rugged dirt roads.

I have heard the phrase ‘gut-wrenching poverty’ used many times, but had never quite appreciated the visceral emotional response this simple descriptor can evoke until I observed the people in these hills and mountains, and witnessed first hand how illness can completely erode livelihoods. It is evident in rounded shoulders, a look of abject defeat in the eyes, and in wracked limbs buried under ill-fitting threadbare clothes.

Over the preceding decades, HIV had cast a very long and dark shadow over the communities in this area. I could not help but relate the individual cachexia that transforms the individual-afflicted by shrinking waists and limbs, up into the demographic erosion of the population at large (Hosegood et al., 2004). Like the afflicted individual, it was the villages demographic-waist, its youth, that were slowly eroding away, leaving the local population dominated by the elderly and the children.

Households and villages in my research area were populated by young boys and girls, wives, mothers, and the retired generation, and men were either older, deceased, or were said to be ‘away’ in city centres, returning infrequently, if returning at all. One of my informants, a HIV community worker and facilitator, would talk of men coming home to die from what families usually claimed was an ‘*unknown illness*’, impressing on me that, despite the decades, the cloud of stigma surrounding HIV had yet to dissipate. (see Clark et al., 2007)

My initial intention for my masters project was to map out the way in which HIV erodes the ability for households to utilise natural resources effectively, and I intended to do this mathematically using systems-dynamics – a modelling approach in which variables, and the relationships there-between, can be explored visually and where dynamic two-way relationships (i.e. feedback-loops) between variables can be defined and explored.<sup>15</sup>

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<sup>14</sup> In my naiveté, I initially thought it paradoxical that people so impoverished might consider the mobile phone to be a necessary household asset given the expense. However, the simple mobile phone has led to some significant changes for Africa’s rural poor, with much research pointing to the opening of markets for agricultural goods (Aker and Mbiti, 2010). However, in this particular research area, people barely engage in subsistence farming, much less anything commercial. Furthermore, electricity and credit costs are not negligible. Indeed, I recall asking one of my informants why people would spend a significant portion of their meagre income on the expense of a phone. He shrugged his shoulders in reply, stating that from his perspective, he did not want to ‘*fall behind*’ or ‘*appear backwards*’.

<sup>15</sup> For example, one dynamic relationship is that the maintenance of household health relies on the ability for that household to exploit local natural resources and *vice versa*. Because HIV can erode productive capacity,

Having read for an economics degree prior to the MSc, I was accustomed to confronting data in neat columns and rows, factors, proxies, and formulae ready to be manipulated, modelled and simulated. What happened in the field was a far cry from my prior data-crunching efforts. To put it simple, I met my ‘data’. I spoke with them and breathed with them. I ate with them, played football with their boisterous children, and I lived, laughed, and cried with them. And I watched them die. The prospect of reducing their lives to a simulated model no longer held any significant academic appeal, and while I successfully completed my research and submitted my dissertation, I did so only by dramatically altering the research parameters and methods. Challenging as it was, I did encounter phenomena that piqued my interest, even though they were only peripherally related to my original aims and interests, and these arose from my confrontation with the complexity of local perceptions and views surrounding HIV.

Myth, stigma, and denialism surrounding HIV was widespread in my study area. While many fully accepted that HIV was a very real disease, just as many questioned, albeit tentatively, its very existence. Some voiced scepticism towards the claimed relationship between virus and syndrome, and many were discouraged from going to get tested for fear of widespread disclosure in the community.

I encountered a variety of circulating memes on the origins of the disease including, for example, that HIV had been ‘injected’ into South Africa’s Black population by the apartheid government as a heinous act of (i) sabotage, (ii) population control, and (iii) revenge for the recognition of its imminent demise. Others speculated that HIV resulted from profit-seeking pharmaceutical companies carrying out a vaccination program that was either (i) botched, though well intentioned, or (ii) a diabolical and deliberate act of drug testing carried out on an unwitting black population. Thabo Mbeki’s now (in)famous observation that ‘*poverty causes AIDS*’, an observation that has drawn much criticism, ire, and academic debate (Nattrass, 2008), was a frequent refrain in the area. And indeed, many villagers pointed directly to the doubts voiced by the country’s political elites, when crafting and delivering their own views.<sup>16</sup>

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this impairs a household’s ability to exploit natural resources effectively, which again, in turn, can result in a further erosion of health. This is merely a simple example, and the realities of micro-simulation modelling are complex, requiring variables, or measurable proxies, and relationships between them to be well-defined and well-understood. One of the more significant challenges in identifying or developing a measurable proxy of ‘HIV’ impact on households, was the stigmatising aspects of the disease.

16 A great deal has been written about the politics of AIDS denialism, in particular Ashforth and Nattrass (2005), Nattrass (2008) where it is claimed that state denialism resulted in the deaths of an estimated 300 000 people. While Nattrass’s state directed polemic has been widely cited, and many arguments against HIV denialism, I wish to point to Fassin’s (2007) work in which he explores the complex rationale behind denialism and its relationship with a complex colonial past. In this, he challenges the moral-foundations of

By 2006 AIDS denialism was a well-known feature of president Thabo Mbeki's administration, and the international community had already voiced outrage and condemnation at his stance, and that of his appointed minister of health, the now deceased Dr Manto Tshabalala-Msimang. The latter will forever be referred to in the annals of South African History under the sobriquet, *Dr Beetroot*, for her controversial stance that vegetables and garlic are alternative treatment mediums for the disease. The AIDS denialist positions of President Mbeki and Dr Tshabalala-Msimang was widely condemned as belonging on the 'lunatic fringe' (Lewis, 2006) and is estimated to have resulted in over 300 000 premature deaths (Nattrass, 2008). The most artful representations of these events, were captured by Shapiro, South Africa's most applauded political satirists (see following page).

Figure 1: Zapiro - Dr Do-Little's AIDS Treatment Crop



the 'righteous orthodox' position towards denialism, i.e. those who challenge the 'Black' position of equipoise on the roots of AIDS.

Figure 2: Zapiro - Lemon is Not a Vegetable



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Along with the AIDS denialist stance promulgated by Dr Manto Tshabalala-Msimang, there is evidence that, whilst eroding biomedical capacity to address the disease, she was at the same time showing tacit support for the use of natural herbal supplements, the most frequently cited example being the micronutrient supplements peddled by the well known AIDS denialist, and businessman, Matthias Rath (Sidley, 2005).

Furthermore, in the post-apartheid atmosphere of Thabo Mbeki's African Renaissance, South Africa's indigenous traditional healers were in the process of garnering increased state recognition through the implementation and promotion of the traditional health practitioners bill, (South African Government, 2007) legislation that sought to provide a regulatory framework, and greater legitimacy, for the practice and profession of African traditional medicine (Devenish, 2005; Leclerc-Madlala, 2002; Watson, 2005).

I had known little about African traditional medicine when I commenced my MSc in rural development, and it was in this area of KwaZulu Natal that I would first encounter traditional healers, and a very different ontological perspective on disease and illness. Traversing steep hillsides while moving from one homestead to the next, it was in these scattered villages that I would for the first time come face-to-face with *tangoma* (Plural of sangoma: spiritualists / diviners) and *tinyanga* (Plural of inyanga: herbalists) – African traditional healers who interpret illness and disease in a manner that deviates considerably from a Western biomedical paradigm.

Up until this point, sangomas and inyangas were known to me only through the media-caricatures encountered by the average White South African, where they are often loosely labelled as witchdoctors, and where the media delights in fetishising and drawing attention to their professed magical and esoteric endeavours. Popular media accounts include professional football teams retaining a *sangoma*'s magical skills to influence the outcome of a game (Mail and Guardian, 2011), or the seemingly perennial accounts of thieves, who, having been apprehended by the legal and justice system, expressed surprise that the *muti* (medicine) they had purchased to guarantee evasion from capture turned out to be ineffective (Mashabane, 2012). Or in a similar vein, one frequently comes across reports of people who attempt to purchase *muti* to sway the opinion of a judge or court in ones favour.

In short, before coming face-to-face with traditional healers myself, I had encountered numerous tales of their claimed magical powers, and the varied ends to which these were applied. While the above examples do not speak to any particular 'healing' aspect of the 'traditional healer', there is nonetheless a well accepted and significant healing dimension to their endeavours.<sup>17</sup> It was at this point that my intellectual interests expanded into the field commonly referred to as medical pluralism.

Following my MSc in development, I returned to the self-same field site a year later to carry out further fieldwork for a subsequent MSc in public health research. In this endeavour, I delved into my nascent and growing interest in medical pluralism. This project saw me immerse myself into a maelstrom of tensions existing between South Africa's health cultures, and the raging HIV/TB syndemic that gripped the country appeared to fuel these tensions while at the same time casting a magnifying glass thereupon.

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17 It has long been established that the term 'traditional healer' is a widespread misnomer, and often used incorrectly, both in the assumption that their methods and practises in some way connect them, and their patients, to a notion of a pure and unadulterated 'traditional' body of philosophy thought and practise, but also in that their methods are recruited to address some vague notion of 'health' and 'healing' that is distinctly 'African'. This is covered in more detail in the following chapter.



As part of my public health dissertation I held in-depth interviews with six traditional healers, exploring their interpretations on disease and illness and their perspectives on the barriers to collaboration with Western biomedical health professionals. From these interviews and discussions would emerge a litany of practices that, in my admittedly Western biomedico-centric view, sounded nothing short of alarming: claims that cancer and HIV might be cured with the right combination of herbs handed down by the whispered voices of ancestors; that diesel and other petrochemicals were used as ingredients in traditional *muti*; and where one sangoma, reaching for an opportunity, offered to sell me what he billed as the most potent love potion in South Africa.<sup>18</sup>

One of the more interesting and fruitful encounters with a Traditional healer was with Doctor (TrDr) Ndlovu, a sangoma who claimed to have been afflicted with tuberculosis in the past and was subsequently treated and cured in Durban's King Edward VIII Hospital. At the time of our meeting TrDr Ndlovu, who had been practicing for over two decades, declared himself to be a *sifuba* (chest) specialist, and claimed to be able to diagnose and treat a number of chest-related diseases using traditional methods.<sup>19</sup> And while he explicitly stated that he could not cure TB, he did claim to be able to diagnose it through observation, after which he claimed to sometimes treat the patient in collaboration with biomedical therapy. Below, is a very brief quote from our first meeting:

*N: ... and if I think that this patient might have the TB, I will ask that patient to cough and I will take those sputums, and I know what kind of sputums are probably for TB.*

*P: By looking at it?*

*N: Yes by looking at it, and I can tell, but sometimes it depends because some of the people they aren't coughing-coughing, so they just cough perhaps once an hour so you [i.e. other healers] can't tell exactly by coughing that this person has TB. But I can identify [TB] with the sputum.*

*TrDr Ndlovu, cited in Andreadis (2007)*

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18 It so happened that a son of this sangoma happened to be my local informant and interpreter during my research, and he himself confirmed the veracity and efficacy of this love potion by referring to his eight half brothers and sisters – apparently all of different mothers – as solid proof of his fathers skills and powers in the amorous field.

19 The community identified a number of 'specialist' traditional healers, and along with TrDr Ndlovu, there was a stroke specialist, a broken bone specialist, and of course the love doctor.

During this discussion, TrDr Ndlovu stood up, ducked under the shallow eave of his round hut and re-emerged almost immediately with an empty scuffed glass coca-cola bottle. This, he explained, was the receptacle he used to collect a patient's sputum, the observation of which was then carried out over a period of three days.

TrDr Ndlovu intrigued me. What did he mean by his claim that he could diagnose TB by observing a patient's coughing patterns, coupled with apparent naked-eye observations of changes in sputum?<sup>20</sup> But there was another aspect of my discussion with TrDr Ndlovu that got my attention. While the other five healers interviewed drew distinct professional boundaries, separating so called 'African illnesses' and 'Western illnesses'<sup>21</sup>, and emphasising the need for specialist practitioners in either domain, TrDr Ndlovu was a sangoma who had incorporated the diagnosis and treatment of a distinct 'Western' disease – TB – into his own traditional practice. And while I know of no method in which the observation of sputum with the naked-eye might help in the diagnosis of suspected TB, this was nonetheless not the sensationalised, or indeed fetishised, evocation of the esoteric, the influence of ancestors, or the breaking of cultural taboo, which I had so frequently encountered when discussing health and illness in the area.

Of course, there are numerous things to consider in my meeting with TrDr Ndlovu. How candid was he being about his methods? Was he really talking about TB, or rather did he have in mind some 'African' illness which he has decided to call TB? Did my own admitted biomedical proclivities lead me to misinterpret the meaning of his words during our interview? Or did I consider enough what his own objectives might have been in conveying an impression of himself as a traditional healer who could also diagnose or treat a Western illness?

Impression management is after all at the heart of all interaction, and there are a good many reasons why a traditional healer might want to convey an impression to a White researcher, of being progressive in his thinking and practise. Not merely an individual steeped in

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20 I was reluctant to press for more detail on what TrDr Ndlovu meant by *observing sputum changes*. Even though I was intrigued by what these 'changes' might be, it had already been stated several times by informants and indeed traditional healers themselves, that one of the primary concerns voiced about my project was the potential exploitation of traditional knowledge by Western researchers and pharmaceutical companies.

21 In her much cited ethnography on the Nyuswa-Zulu, Harriet Ngubane (1977) distinguishes between diseases of a natural aetiology '*umkuhlane*', and those of a supernatural aetiology '*ukufa kwabantu*' as diseases with a supernatural origin, or '*diseases of the African people*'. The latter referring to diseases that conform to an African ontological and cosmological framework of aetiological explanation and understanding. Pienaar *et al* (2004) highlight that there is no ritualised aspect in the treatment of *umkuhlane* diseases where traditional healers are said to readily refer patients to 'Western' clinics and hospitals. See also Ellis (1996) for a biomedical professional's view on this.

esoteric knowledge and skill but a traditional healer who wanted to appear to respect biomedical knowledge as much as he demanded respect for indigenous approaches.

While I cannot entirely attest to the veracity of TrDr Ndlovu's claims given the limitations of my methodological approach in the project<sup>22</sup>, however, what I did manage to verify within the local community, was that TrDr Ndlovu was indeed regarded as an excellent *sifuba* specialist. One with a widespread reputation for diagnosing and treating TB.

In the public health and biomedical domain, African traditional medicine is often explicitly or implicitly classified as a defined system running parallel to Western biomedicine (Kale, 1995), leaving one with the impression that there are distinct and discreet boundaries of practice. However, I quickly discovered that rather than discreet and separate systems, these boundaries are porous and overlapping. Practice and thought intersect, technologies and terminologies, ideas and body-concepts are all subject to cross-cultural migration, and the distinction made between *Western illnesses* and *African Illnesses*, and between *Western medicine* and *African medicine*, are frequently blurred. TrDr Ndlovu's professed skill in treating a decidedly biomedically defined affliction is only one of these examples.

From the biomedical perspective African traditional healers have long been considered potentially valuable in the aim of expanding primary health care delivery (Homsy et al., 2004; Madamombe, 2006; WHO, 1995). And South Africa's plural medical environment has over the last few decades been an interesting arena in which to observe the political dimensions of knowledge relating to medicine and health and most interesting have been the calls for greater inclusion of indigenous knowledge systems in the treatment of diseases such as HIV and TB (Wreford, 2005a, 2005b). But the challenges of this raise notions of the treatment legitimacy and how such legitimacy is judged and established, and indeed by whom. This has led to significant complications and the rise of a number of questionable interventions for HIV. The example below is but one I have personal experience of.

While undertaking my MSc research in KwaZulu Natal I stumbled across a wildly popular 'herbal' remedy called *uBhejane* (Zulu: Rhinoceros). *uBhejane* emerged from the fertile soil of AIDS denialism and has received critical attention in the South African press, from activist groups, as well as the biomedical establishment (Bateman, 2006; Cullinan, 2006; Schulz-Herzenberg, 2007; TAC, 2010, 2008). The concoction is purportedly made by combining eighty nine different herbs and was 'dreamed up' and is mass-produced in a

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22 Had I not been limited by time constraints, I certainly would have used a more ethnographic approach to this study, immersing myself into the community, and observing traditional healers in practice, rather than just relying on interviews.

factory-like setting by a man named Zeblon Gwala. Zeblon openly refers to and advertises *uBhejane* as a natural alternative to antiretrovirals (Bekker, 2008).

I had been made aware of *uBhejane* by a local informant in my research area in the KwaZulu Natal hills. While this informant was not able to provide much in the way of information, he was able to direct me to a social worker based in Pinetown, a residential area on the outskirts of Durban, who was able to provide me with more details about this herbal treatment.

During my meeting with this social worker I informed her of my interest in African traditional medicine and subsequently found myself on the receiving-end of a sustained barrage of proselytising. The passion and excitement with which she talked about *uBhejane* continued throughout our talk and, beaming with pride, she disclosed that she had even suggested to her clientele that they should consider using this herbal treatment. She spoke about *uBhejane* with effusive pride and lauded it as a product of indigenous knowledge and not a pharmaceutical company's latest synthetic cocktail. She proceeded to highlight that this herbal remedy had received backing from local and national politicians, and beaming she finished off with what I assume was meant to be the *coup-de-grace*, that *uBhejane* had been sent to the local university for pharmacological testing.

I naturally enquired what the results of these tests indicated and she hedged, claiming not to know. But she did so in a manner that suggested this was beside the point. Zeblon Gwala was doing exactly what the medical establishment had for years been demanding - allowing his indigenous remedy to be scientifically reviewed. Threaded into her argument as sub-text, was that unlike antiretrovirals, *uBhejane* contained only herbs and was therefore a 'non-toxic' and 'natural', ergo, unlike pharmaceuticals with their many side-effects, *uBhejane* could only help, not harm. She mentioned that the remedy was being sold from a dedicated outlet only a few blocks from the social work offices and I took the occasion to visit the outlet and inspect this herbal concoction myself.

The outlet was tucked away in the small-business sector of Pinetown, overshadowed by a high-rise office block and set back from the road-side bustle of speeding traffic. The two receptionists in the outlet were dressed in blue uniforms that left one the impression that they were qualified nurses, which they were not. The store was clinical and smelled of disinfectant and chemicals. The floor was tiled in white, and the reception desk topped with a white formica counter-top. The room was austere, and barren except for the shelves behind the service counter which were stacked full of *uBhejane*.

The two-litre bottles contained a dark brown liquid and there were two different types. A white-capped bottle and a blue capped bottle. Speaking to the two 'nurses' who were

surprised at my entrance and interest in the product, I learned that the contents of the white capped bottle was responsible for boosting white cells (of course!) i.e. improving CD4 count, while the contents of the blue-capped bottle was responsible for fighting the virus, i.e. reducing the viral load. The explained treatment protocol for *uBhejane* is complex, with doses of one of either concoction rotated, and taken at specific times.

Speaking to the ‘nurse’ receptionists, I said I had heard about the *sangoma* who had made *uBhejane*, and wanted to know if he was available to meet. This prompted much laughter, and it soon emerged that the source of their amusement was my description of Zeblon Gwala as a *sangoma*. An *inyanga* (herbalist) then? Laughter again. It appears that Zeblon claimed to be neither an *inyanga* or a *sangoma* and that my characterising him as a traditional healer of any ‘type’ was an amusing misapprehension. His remedy however, was widely considered to be a ‘traditional medicine’ derived from indigenous knowledge and methods. Zeblon Gwala was not there to meet in person, but his ‘deputy’ was. Through my discussion with him, combined with other written accounts, we can build a picture of Zeblon Gwala and his herbal miracle cure *uBhejane*.

*uBhejane* is a remedy which was purportedly sent to Zeblon Gwala in his dreams while working as a long distance truck driver. While he claims no esoteric powers, nor does he claim to be a traditional healer, he does claim that his dreams were sent to him by his deceased grandfather who was a *sangoma*. The concoction is purportedly made with 89 different herbs, and while it has been sent to be analysed by Professor Gqaleni Nceba, a pharmacologist at the University of KwaZulu Natal and a member of the Interim Traditional Health Practitioners Council of South Africa, these were only very basic *in vitro* test to determine if *uBhejane* was cytotoxic (Bateman, 2006).

These tests indicated that *uBhejane* was not toxic to cells, however, upon releasing the report on this, Professor Nceba has warned on the potential for misuse and misinterpretation of these results, emphasising that he has no evidence that *uBhejane* was effective at decreasing viral load and increasing CD4 count as claimed. Claims that *uBhejane* had been promoted by politicians are not exaggerated, as the then provincial health minister Dr Tshabalala-Msimang, the KwaZulu Natal health MEC, as well as the then mayor of eThekweni (Durban) are reported to have provided either explicit or tacit support for *uBhejane* and Zeblon Gwala (Cullinan, 2006).

In 2006, the political opposition party, the Democratic Alliance, attempted to lay charges of fraud against Zeblon Gwala for making false claims about the efficacy of *uBhejane* as well as for contravening the Medicines and Related Substances Control Act, however the case

was apparently dismissed by the presiding judge on the grounds that there was not enough evidence to suggest that *uBhejane* could not be used to treat HIV (Zulu, 2006).

Following the trial, Professor Herbert Vilakazi, a sociologist and staunch supporter of Zeblon Gwala and *uBhejane*, claimed that South Africa's constitution mandates that cultural practices such as African traditional medicines be recognised, and that *uBhejane* need not be shackled by medical regulation as it was a traditional herbal mixture (Zulu, 2006). This pronouncement also appears to go against the grain of the long debated traditional health practitioners bill which states that one needs to be a registered traditional healer to make any attempts at treating patients with HIV (South African Government, 2007), and Zeblon Gwala was certainly not claiming to be a traditional healer.

The issue becomes more complicated as in more recent years Zeblon Gwala appears to have attempted to get *uBhejane* registered with the Medicines Control Council (MCC), and reported to the press that he had in fact obtained a certificate of registration. However, the MCC denied this branding Zeblon Gwala's claims as misleading and untrue (Langa, 2010).

One might legitimately question why people should not be allowed to choose to use *uBhejane* if they consider it to be an available avenue for HIV treatment. This argument is slightly muddled if one considers that both the 'nurses' in his Pinetown distribution, and Zeblon Gwala himself have been recorded on camera saying that they strongly discourage patients mixing *uBhejane* with antiretrovirals, and that patients should only use one or the other (CHMT, 2008). The argument used by Zeblon to justify this is that they have no tests showing what the effect might be of taking *uBhejane* and ARVs together, and thus people should instead make a considered choice between them. Nurses at the dispensary have also been recorded suggesting that after a course of treatment with *uBhejane*, an HIV test will indicate that no virus will be present, and thus unlike ARVs *uBhejane* did not need to be taken forever (CHMT, 2008). The implication of this, of course, being that *uBhejane* was not a treatment, but a cure.

Furthermore, a claim has also been made in the South African Medical Journal suggesting that qualified nurses in a clinic in the town of Pietermaritzburg were advising patients to put their names on a waiting list for *uBhejane*, and are alleged to have suggested that it will be '*..rolled out like ARVs*' (Bateman, 2006).

*uBhejane* raises a number of interesting and disturbing issues that I wish to highlight. Firstly, *uBhejane* is clearly being sold as a treatment for HIV, not a traditional illness that correlates with HIV or an affliction whose explanation derives from African cosmology.

Closely related is the second issue that the treatment protocol for this herbal intervention is couched in, and leverages, the language of biomedical science. Terms like *viral load* and *CD4 count* are widespread and now commonly understood and Zeblon Gwala capitalises on this by leveraging these concepts, and goes as far as creating two separate interventions – the white and blue capped bottles to mirror Western biomedical principles of immunity mechanics. The veneer of biomedical authenticity, and his repeated attempts to shroud his product in scientific and biomedical authenticity and recognition, is deliberate. This revolves not only around the medication, but also the clinical representation of staff and premises where *uBhejane* is sold.

Thirdly, Zeblon is very careful to state that he himself is not a traditional healer, but at the same time the claimed source of the remedy - a dream from his sangoma grandfather - is unmistakably couched in terms that are clearly understood by those versed in African philosophy and indigenous knowledge.

Fourthly, by creatively engaging with aspects of Western science - i.e. setting up an outlet with a clinical veneer, using biomedically-sounding treatment protocols, and using receptionists dressed as nurses - Zeblon casts himself in the same arena as the pseudo-scientist donning a thin veil of apparent biomedical legitimacy. He treads the middle ground by leveraging and exploiting the ‘traditional’ while at the same time appearing to engage head-on with the demands of the medical and scientific community. There is just enough of the ‘modern’ and ‘scientific’ in terms of creative engagement with these domains, balanced with just enough of the ‘traditional’, to walk the middle ground of ontological polarities, and provide a ‘natural’ ‘tested’ herbal medicine of indigenous origin.

Zeblon Gwala effectively positions himself to leverage the uncertainty of those sceptical of Western medications and the widespread concerns of the toxicity of Western medications. He leverages the yearning in those wanting a cure for HIV to come through a traditional route rather than the industrial pharmaceutical complex. Were his traditional medicine shown to be effective, such a discovery would legitimate ‘relegated’ indigenous knowledge and elevate it to a position of parity with respect to Western biomedicine. Or at least this is the manner those of Western orientation might perceive this. Certainly, given that a vast proportion of South Africa’s population utilise African traditional medicine one wonders in what context arguments of ‘parity’ and ‘power-asymmetry’ between these healing avenues, hold true.

The social worker who pointed me in the direction of *uBhejane* did not merely state her rationale on why she believed it was a legitimate medication – but the manner in which she

conveyed this was clearly that she *wanted* it to be legitimate. That Zeblon Gwala was engaging on the same playing field as biomedical science was legitimacy enough.

In the interests of fairness and symmetry, I certainly do not want to give the impression that Zeblon Gwala, or his affiliated political backers should alone be criticised for the attempted legitimisation and promulgation of *uBhejane*. It is necessary to highlight that the Western biomedical and pharmaceutical establishment are by no means exempt from criticism in their endeavour to bring us healing ‘products’. These efforts certainly do not always remain within the boundaries of ethical practice. Indeed, the physician and writer Ben Goldacre (Goldacre, 2008) provides an accessible and readable polemic of the many strategies used by the pharmaceutical industry to try and make a pharmaceutical product appear more efficacious and legitimate than it may in reality be. These include the burying of ‘*bad*’ or contrarian data; the manipulating of study population parameters to benefit results; the selective publication of test results; and any of a number of techniques used to make products appear more safe and effective than they really are.

Like Zeblon Gwala, pharmaceutical companies are known to leverage perceptions of legitimacy and authenticity in their quest to sell products. While Zeblon Gwala attempts to leverage the power of people’s belief in esoteric indigenous African knowledge, Western pharmaceutical companies similarly leverage widespread belief in esoteric scientific knowledge.

In 2008, I happened to be passing once more through the KwaZulu Natal hills, and I took a detour through the area where my research project had been based. I had wanted to pay my respects to a number of people and tried to visit as many of those that had participated in my project as I could. One of these healers was TrDr Tshabalala, a *sangoma* who was in her mid-twenties, and was much younger than the others I had interviewed.

Unlike the others, TrDr Tshabalala had been able to educate herself at the local school, and had attained her matriculation (high school) certificate. As a result, her English was far better than the other *tangoma*, and we were able to communicate far easier as a result. While the others looked venerable, carrying the gravitas of age and experience, and commanding the respect, and indeed fear<sup>23</sup> from the local community, TrDr Tshabalala looked youthful, and

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23 My local informant whose own father was a sangoma claimed that people feared traditional healers, and indeed I should as well, as they knew what you were thinking all the time. You could not hide your thoughts or intentions from them.



positively naïve in comparison. While others looked weather beaten by life, TrDr Tshabalala's wide smile barely raised a wrinkle.

She lived with her family on a piece of land that lay on a slope of the valley in which I had been working, and my route to get to her homestead required a long trudge down meandering footpaths, and up steep dirt roads that were creased with deep rivulet-cut grooves caused by heavy summer showers. Arriving at her somewhat isolated homestead, I was greeted by her mother who explained that her daughter was not at home, and that I would have to come back next month if I wanted to consult with her.

I was, I admit, quite disappointed. Though she was still quite young she had been practicing as a *sangoma* for around five years, and while the other *tangoma* had been more than willing to address my persistent questions to help me reach towards some level of understanding, because of her superior command over English, TrDr Tshabalala was always much better at expressing herself and explaining some of the more nuanced aspects of the philosophy and practice of African traditional medicine. I asked her mother where she was.

"In Pietermaritzburg... she's going to college there."

I was pleasantly surprised. "Oh!? What's she studying?"

"*Nursing...*" came the reply.

It was this revelation that held particular interest for me. How, I mused, could a sangoma balance the roles of nurse and traditional healer? How would she manoeuvre around any critical ontological and epistemological tensions that would almost certainly arise by her holding dual roles? Where, in effect, would her loyalties lie?

Indeed, this very question can be broadened out significantly as a nurse or doctor need not be a qualified *sangoma* to find themselves in a critical position in the therapeutic arena. One in which they have to mediate professional expectations and training, alongside cultural affiliations and loyalties. This is alluded to by the anthropologist Adam Ashforth who writes:

*"There is no reason to presume that Africans working within the medical system as doctors, nurses, and technicians are completely severed from all cultural forms and practices of the world in which they live, nor that their professional practice and personal lives conform seamlessly with the ideological stipulations of 'scientific' medicine..."*

*Ashforth (2005, p. 240)*

This line of inquiry served as the catalyst for the thesis in the pages ahead.

## ***Chapter 1: Introduction***

Public health provision in South Africa is a complex undertaking where a ‘Western’ oriented systems of healthcare is but one amongst a plethora of avenues in a landscape health care. Thus far the foreword has introduced many of the complex realities of healing in South Africa, and the focus on this particular thesis is to examine how ethical and ontological contestations can, and do arise within South Africa’s state-run hospitals. This project in public health is part hospital ethnography, part narrative exploration, and part ontological and epistemological inquiry, and in these pages I interrogate the intersection of science and society, belief and practice. I explore fluid definitions of therapeutic legitimacy and the porous boundaries of biomedical practice.

My aims in the study were to explore the collision of African traditional medicine and Western biomedicine, and how the former emerges within the biomedical-space. I explore this interface between African traditional medicine and Western biomedicine through (i) confined tuberculosis patients, and (ii) biomedical professionals - predominantly nurses and doctors. This project is carried out within two defined research sites, namely Barberton’s specialist tuberculosis hospital, and Barberton general hospital. My guiding research questions were as follows<sup>24</sup>:

- What are the views and perspectives of nurses and doctors of the plural medical landscape in general, and more specifically to the emergence of African traditional medicine within hospital boundaries?
- How is African traditional medicine said to arise in the hospital space, and what are the views of nurses and doctors on how this is, and should be confronted and managed?
- What are the views and perspectives of hospital-confined tuberculosis patients on the plural medical landscape? How have tuberculosis patients traversed this landscape?

It is traditional to begin a thesis introduction by outlining the shape and contours of the work to follow. I have presented the outline of this thesis nearer the end of this chapter, and would

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<sup>24</sup> A discussion of how these research questions evolved throughout the course of the thesis are outlined in the methods section to follow.

ask that the reader bear with me as I relate this brief outline of aims and research questions to events occurring during this thesis.

Midway through my PhD fieldwork I interviewed a senior nurse practicing in the specialist tuberculosis hospital on the outskirts of the rural town of Barberton, South Africa. Matron Makeba was stout, professional, and her crisp epaulettes evoked a regimental air. She was a member of the hospital management team and came across as efficient and authoritative, a seasoned nurse who, on observation, led by example, brooked no argument, and was critical of incompetence. I observed that tuberculosis patients afforded her deference and respect and her opinion and words carried a great deal of weight with colleagues both junior and senior.

I felt a mixture of relief and guilt that she had consented to give up an hour of her time to be interviewed. Relief because our interview occurred at the end of a particularly trying week of stonewalling from nurses and doctors who were too busy, or uninterested, in participating in the project, and guilt because I was keenly aware of how critically understaffed the TB hospital was and an hour of time with Matron Makeba was not an inconsiderable opportunity cost.

Our interview was held in her office in the TB hospital, our words measured out by the monotonous clicking of an oscillating fan trying valiantly, though failing, to keep the Mpumalanga summer heat out of the confined space. Arriving thoroughly dishevelled from my bicycle commute over Barberton's heat-shimmering roads, I felt somewhat out of place seated in an office that appeared to be a shrine to order and efficiency. Official health department patient files and lever-arch folders were aligned regimentally on tall shelves, or rested in neat vertical stacks on surrounding surfaces. Phone calls and frequent nurse drop-ins during our meeting were dealt with efficiently and authoritatively, not entirely impersonally, but with little banter or social intercourse nonetheless. This said, Matron Makeba was not abrupt or impatient during our discussion, but calm and measured, approaching each question with patience and consideration, and pausing often to think through and construct a suitable response.

At the time of our meeting, I had already formally interviewed seven nurses within the tuberculosis hospital, and more than twenty nurses and doctors in the nearby general hospital. I had also listened to half a dozen tuberculosis patients recount their stories of illness and subsequent health seeking, and I was rapt by accounts of the various therapeutic avenues followed, and the trials and travails that ultimately drew these poor suffering souls into the institutional embrace of Barberton TB hospital.

Central to these interviews and narratives were stories about the plural medical landscape, of how patients often went first to traditional healers - *tangoma*, *tinyanga*, or faith healers - before they availed themselves of the town's biomedical institutions. Emerging from these discussions was a oft-repeated refrain that patients and traditional healers frequently conflate tuberculosis with an affliction known in siSwati as *tindzaka*, an 'African' affliction - what Harriet Ngubane would have referred to under the rubric of *ukufa kwabantu* - that can best, though inadequately, be translated as a pollution.<sup>25</sup> In this, *tindzaka* does not denote an idea of pollution as in the domain of physics and chemistry, but rather in the metaphysical sense, a ritual pollution associated with widespread belief of the influence of forces, spirits, and ancestors on health and wellbeing. In the case of *tindzaka*, the diseases is associated with notions of morality and 'correct' behaviour.<sup>26</sup> The affliction, I would come to learn, is said to arise as a result of moral delict - specifically the breaching of restrictions surrounding sexual intercourse during life events such as birth, abortion, and death.<sup>27</sup> The symptoms of *tindzaka* are said to include persistent coughing, disturbed sleep, weakness and weight loss and as such it is perhaps not too surprising that it is often conflated with tuberculosis by traditional healers, and indeed by those afflicted.

I raised the notion of *tindzaka* being conflated with tuberculosis with matron Makeba, and it was here that her careful and controlled exterior showed a few cracks born of, what I am quite certain was, frustration and irritation.

*On Monday, a patient, this man came, and he said to me, you know, you treat tindzaka here very well. I'm getting better again, putting on weight... resting... I feel good... and I told him, this is not tindzaka, this is TB. You are being treated here for TB, all your medications are for TB. Most people here, not just in the hospital, but in Emjindini [she waves in the direction of the tribal trust that adjoins the town] believe this tindzaka is a real thing, but really there is no such thing. Tindzaka is just another name for TB.*

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<sup>25</sup> The direct translation of *tindzaka* from siSwati to English has been a challenge. I have heard it roughly described as a pollution (Professor Robert Thornton, personal conversation) and this is generally, though reluctantly, agreed upon by the local people to be the closest possible interpretation. There is in fact no easy translation, though Rycroft's (1981) concise siSwati dictionary defines *tindzaka* as a term referring to a weak or lazy person. It is not too much of a stretch to then see why it is used to refer to an illness.

<sup>26</sup> Douglas (1966) provides a general discourse on pollution in relation to taboo and the maintenance (or not) of social and cultural cohesion, while in her work with the Nyuswa-Zulu Ngubane (1977) describes *Umyama* (Zulu lit. darkness) as a symbolic mystical pollution, in an identical fashion in which I encountered the term *tindzaka* amongst the Swazi. However, she describes it not only as a contagious affliction, but in terms of a marginal state between life and death. Not merely a symbolic afflicted state, but one that itself diminishes resistance to disease – indeed not dissimilar to how we would describe the effects of HIV.

<sup>27</sup> In their ethnographies on Swazi culture, both Marwick, (1940) and Kuper (1965) describe a similar affliction called *lugola / logolo*. These are described in identical terms that I encountered the explanations for *tindzaka* as a wasting illness that leads to the coughing of blood and arises when restraints on sexual activity during periods of menstruation, or surrounding birth, are ignored.

And a short while later:

*If people want to go to the traditional healer for tindzaka, they are welcome to go. But while they are here [in the tuberculosis hospital confines] they are not allowed to use imbita.<sup>28</sup> We don't want this other stuff in here as it just makes complications. Sometimes we have to say to them **please** just finish our treatment first, and then when **we** have had our chance, the sangoma can have theirs. But do **ours** first... but you know sometime they don't listen.*

Matron Makeba

Matron Makeba's view on the conflation of TB and *tindzaka* raises a number of interesting issues. Firstly, her views evidence her allegiance to a biomedical model that claims authority to interpret and define the true nature of reality (or indeed the true reality of nature), and she stakes out a clear ontological position with regards to the interpretation of illness, in this case tuberculosis.

*Tindzaka*, in Matron Makeba's view, is not an inherently 'real' affliction. She sees no logic in the causal explanation being the result of some moral delict, the result of some notion of ritual pollution or disgruntled ancestors. Secondly, while she maintains that there is no such thing as *tindzaka*, she does concede that the term functions as a widely used cultural label relating to a constellation of symptoms that mirror those of tuberculosis. *Tindzaka*, much like now defunct Western terms *consumption* or *phthisis*, is considered by Matron Makeba to be a pre-scientific, pre-medical label for tuberculosis.

To phrase this another way, Matron Makeba draws a clear association between the culturally specific emic affliction *tindzaka*, and its 'universal' etic correlate tuberculosis, relegating the former to a position of culture-bound misapprehension.<sup>29</sup> And while Matron Makeba expresses that patients are free to seek help from a traditional healer if they suspect that they might have *tindzaka*, she is quite clear that such an avenue should only be explored after biomedical intervention.

I encouraged Matron Makeba to expand on her view of the African traditional - Western biomedical nexus, to which she then launched into the thorny, and apparently vexing issue of the concomitant *mixing* of medications from different therapeutic avenues.

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<sup>28</sup> *Imbita* is the siSwati term for traditional medicine, and is interchangeable with the widely used Zulu term *muti*.

<sup>29</sup> Indeed, this relationship between emic culturally constructed illness, to emic universal illnesses has been used in the medical sciences in Africa many times. In the domain of psychiatry, Patel *et al* (Patel and Mann, 1997; Patel, 1995; Patel et al., 1995) attempted to create an emic case-finding instrument - a one-way 'Rosetta stone' in which culturally defined emic afflictions in Zimbabwe could be translated into universal etic (read: Western biomedical) disease categories. See also Langwick (2007) for a similar collision of 'diseases' concepts in Tanzania, with the 'conflation' of *degedege* and *Malaria*.

The simultaneous mixing of medications from different health avenues is considered dangerous, and indeed *imbita* is not permitted within the hospital confines as it ‘*makes complications*’.<sup>30</sup> However, what are these potential complications that result from a mixing of medicines from different systems? While there is no robust evidence to suggest what these might be, Matron Makeba and many other nurses and doctors have well formulated arguments at hand. Prominent among these arguments are that allowing African traditional medicines to be consumed within the hospital confines would be to deprive the opportunity for the patient to see that the biomedical avenue and interpretation for their affliction is the legitimate route. Matron Makeba is particularly concerned with making sure patients not just follow through with biomedical therapy, but in doing so wants to ensure patients are not in two minds about the reality of their affliction.

Patient equipoise and ambivalence surrounding the biomedical interpretation of tuberculosis is not desirable, and indeed belief in ‘cultural affliction’, and African traditional medicine in particular, has been implicated in a number of academic publications, however marginally, in negatively influencing patient behaviour and subsequent adherence to TB chemotherapy. Which in turn has been implicated as a factor influencing South Africa’s high rate of TB drug defaulting. (Dong et al., 2007; Edginton et al., 2002).

*If they mix African with Western [medicines] how will they know which one cured? They might think that there is something real to the imbita when it was in fact our [Western] medicines! And then people in the community will think it is the imbita that cured.*

Matron Makeba

While another argument runs as follows:

*If they [the patient/s] mix, the mixing could be dangerous and toxic for the liver, but if they don’t tell us they are mixing, then we might [wrongly] think it is the TB medications [causing liver stress]! And what if they mix, and the mixing itself is toxic? For example we know which [Western] medications can be taken together and which are not able to mix. But the ingredients of imbita are secret. Only the traditional healer knows [the contents]. The patient doesn’t know, so its best not to mix.*

Matron Makeba

In the first of the above quotes, Matron Makeba objects to the concomitant use of Western and African traditional medicine, as in doing so potentially leads to a misapprehension about what the real cause of the affliction is, and by extension the legitimate intervention. Matron

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<sup>30</sup> This restriction on *imbita* use within the TB hospital confines is confirmed by patients. I discuss this issue at length in chapter five.

Makeba expresses particular concern that allowing the ‘*mixing*’ of treatments might only fuel uncertainty and the misapprehension that leads to a conflation of a ‘culturally-constructed’ with a ‘real’ disease interpretation, and this represents a seemingly illegitimate challenge to biomedical therapy. There is also the implication that African traditional medicine may misleadingly appear to be legitimised as a result of mixing.<sup>31</sup> Matron Makeba not only wants the patients to get better, but she wants the patients to know why they got better and who was responsible.

In the second of the two extracts above, Matron Makeba’s discussion shifts from social and cultural perceptions to an argument that is scientific and body-centred. The consumption or mixing of traditional medicines alongside Western medicine is assumed to be potentially complicating, an unwelcome addition to an already complex biomedical intervention. Matron Makeba concedes that biomedical tuberculosis chemotherapy is in itself a potentially toxic treatment route, placing significant stress on the liver, and it is a treatment avenue that needs careful monitoring. In her opinion, in incidents of apparent hepatic stress, she suggests that it would apparently be complicated to ascertain whether this results solely from the chemotherapy; or because of a the clandestine and parallel use of African traditional medicine.

In espousing her views, Matron Makeba is not only defining the ideological boundaries of legitimate knowledge and intervention, but also the physical boundaries of practice. The controlled and surveilled confines of the tuberculosis hospital are ostensibly a biomedical space in which a normative view of tuberculosis treatment is promoted – and where a normative view of patient behaviour is expected. Non-biomedical ideologies, particularly those that have been shown to stand in direct conflict, for example the notion that one might have *tindzaka* rather than TB, are quite evidently unwelcome.

In Matron Makeba’s view, biomedical conflict with African traditional medicine in the realm of tuberculosis, is both ideological, and operational, and she expresses very real concerns about the potential consequences of conflict in the arena of infectious disease control, consequences that move beyond the biomedical boundaries of the hospital, and into the

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<sup>31</sup> This is not the first instance in which it has been suggested. Cook (2009) relates a story of a patient who, when diagnosed with AIDS, attended a doctor and began treatment with ARVs in secret, and for fear of stigma, had not disclosed this to her family. At the same time her parents ignorant of her AIDS status compelled her to see a sangoma through which she then also started receiving treatment. Upon getting better her family celebrated. The sangoma, thinking he was the source of healing asked that a feast be held in the community, leading to potentially misleading legitimisation of the sangoma. That said, on a biomedical level the sangoma is likely to not have been able to help his patient with HIV, however, given that illness extends far beyond individual physical boundaries, I would argue that the sangoma may have been instrumental in ‘healing’ in a much wider social sense, or legitimising her return to health in the family network.

community at large. In this we have an opportunity to explore the ethical quandaries raised as a result of cultural and medical pluralism, the decidedly contentious grey area spanning the medico-ethical principles of patient autonomy and beneficence.

While matron Makeba assumes a stance rooted firmly within the biomedical model, it would be misleading to extrapolate from this and to assume that all biomedical professionals in the town of Barberton espouse a similar position. I do not use the example of matron Makeba to demonstrate universally held views within Barberton's biomedical professional community. Rather I use this example to introduce the complex reality in which biomedical professionals operate, or at least appear to operate, and to illustrate how a professional, such as matron Makeba, position themselves in relation to the realities of the plural medical landscape and in the context of infectious disease control. The reality is that the biomedical domain is only one amongst multiple therapeutic avenues within Barberton, and furthermore, as will be seen in later chapters, the collective of biomedical professionals working within this domain hold views and perspectives that span ontological and ideological boundaries. While to Matron Makeba, TB and *tindzaka* are interchangeable terms, or more accurately *tindzaka* is a misapprehension that should be translated as tuberculosis, to many other biomedical professionals I encountered, these are distinct and separate afflictions where the biomedical host-environment-pathogen paradigm is as real and true as the African traditional paradigm where affliction is explained in relation to a complex socio-moral framework. For example, a biomedical professional who would certainly disagree entirely with Matron Makeba can be found in Nurse Lamula, a paediatric nurse based in Barberton general hospital, which lies only a few kilometres over heat shimmering roads from the specialist TB facility.

Nurse Lamula is in her fifties, and like matron Makeba, her role as a professional nurse spans decades. She too commands respect from colleagues and patients, however, she is also held in some disregard, with no small amount of veiled contempt within some hospital circles. The reasons for this is that though she is a very experienced professional nurse, she is also a qualified and practicing sangoma, a diviner with deep knowledge of traditional remedies and interventions. Those who hold her with suspicion, do so because they interpret African traditional medicine and Western biomedicine as conflicting and entirely incompatible paradigms, and by extension consider her 'foot-in-each-camp' philosophy to be



a conflict of interest, and even potentially detrimental to her patients. Some consider this conflict of interest ideological, others consider it economic.<sup>32</sup>

I interviewed nurse Lamula in an empty two-bedroom ward in Barberton general hospital's run-down maternity wing. The room was occupied by two rather dilapidated beds with thick foam mattresses, and was shaded by faded threadbare curtains whose indeterminate original colour had long since been bleached away by the sun. While run down, the ward was neat and tidy, and the fug of disinfectant from the cleaner's morning passing, still hung heavy in the close atmosphere. Like the majority of my interviews with nurses and doctors, my discussion with nurse Lamula occurred during a lull in service, and over a staff handover period when there were more hands to deal with the practicalities of patient care.

Since I had heard of TrDr Tshabalala going off to nursing school so many years before<sup>33</sup>, I had long mulled over how an individual who claimed expertise and status across potentially conflicting professional boundaries balanced their professional roles. And in nurse Lamula, I had the chance to interrogate her dual position. Did patients expect a different 'type' of understanding and treatment because of her dual role? Did she ever encounter a conflict regarding disease interpretation, and did this lead to some element of cognitive dissonance? Is she expected by hospital colleagues to leave any 'cultural baggage' at the institutional boundaries? and conversely, do her patients in her private traditional practice expect her to leave the 'cultural biomedical baggage' behind? Does one paradigm augment the other, and does her dual professional role ever compel her to assume a position as cultural mediator between therapeutic ideologies, and this with respect to both the positioning of herself, and the advising of her patients?

While I admittedly see African traditional medicine and Western biomedicine as two separate and distinct healing avenues, this does not mean that nurse Lamula, and indeed other biomedical practitioners do so as well. While the above heralds some of the discussions that follow in later chapters of this thesis, at this moment I wish to highlight nurse Lamula's opinion on the *tindzaka* / tuberculosis conflation raised previously.

During our meeting, I raised the issues of the *tindzaka*-tuberculosis conflation that had been so thorny for matron Makeba, and nurse Lamula did not hesitate in agreeing that such a conflation did indeed exist, however she disagreed entirely with the opinion expressed by some that *tindzaka* is merely TB by another name. For nurse Lamula, these two afflictions

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<sup>32</sup> While TrDr nurse Lamula practices as a biomedical practitioner in a free-for-service state run facility, her practice as sangoma is a private fee-for-service. Some people within the hospital went so far as to charge that she was abusing her position in the hospital to recruit people to her private practice.

<sup>33</sup> See end of previous chapter

have a very similar constellation of symptoms, however, she claims that it is too reductionist and misleading to assume that because of these similarities, this then means that they are in fact the same disease.

*These are not the same diseases. People with TB **must** be treated by a doctor. They must go to SANTA<sup>34</sup> [TB hospital], but tindzaka can only be treated by a sangoma.*

*For tindzaka, the way you tell them apart is very specific, and requires that you know when people are coughing. If a person is coughing at this specific time of the afternoon, then I know it is tindzaka, the coughing is not the same [as TB]. It might seem the same if you don't know, but its not the same.*

*You see it is difficult sometimes because there are many sangomas now, and they are not trained very well, so sometimes they will think it is tindzaka when it is TB, so in that case they don't refer [patients to the hospital]. And this is a problem when it is TB. They are infectious and they are in the community, and the sangoma doesn't know, and then even **they** are in danger.*

*Nurse Lamula*

The conflation, in nurse Lamula's opinion, arises for a number of reasons. Firstly she suggests that many biomedical practitioners, particularly doctors, were not familiar with the distinction. And because of the tendency to test for TB and exclude differentials with sputum testing, she did not feel that biomedical practitioners were driving the conflation. Instead, she highlighted the large number of poorly trained traditional healers, as well as the flood of charlatan healers preying on peoples fears and ignorance.<sup>35</sup>

The conflation, as she later suggests in a more informal discussion, are not merely ideological and ontological, but revolve around economics as well. The primary reason for biomedical practitioners wanting African traditional healers to be able to recognise the signs and symptoms of diseases like TB and HIV is so that people can be referred to obtain biomedical treatment quicker (Colvin et al., 2003; Peltzer et al., 2006). However, herein lies a challenge as asking traditional healers to refer suspected TB cases to hospital, one is

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<sup>34</sup> Barberton tuberculosis hospital, now run by the Mpumalanga Department of health, used to be managed by SANTA, the South African National Tuberculosis Association. Despite the change in management, it is still referred to as SANTA.

<sup>35</sup> Her observation about poorly trained healers was significant on a number of levels. After nurse Lamula spent time answering my questions, I gave her the opportunity to ask questions of myself. Her own questions revolved around asking for my advice on how she could leverage her own medical training, and establish herself as a 'trainer' for sangomas, and help teach them about aspects of hygiene. In effect, she wanted to leverage her dual-roles and position herself as a trainer and consultant of sorts. This did not only extend to consultancy, as she had quite a complex business proposal that included selling products to sangoma that would have her 'biomedical' stamp of approval – specifically, she wanted to market glass bottles for the hygienic storing of herbs. Indeed, the reason for disclosing her plans was to see if I could help her source a factory that would make bottles cheaply.

effectively asking them not just to accept a challenge to their healing authority, but to suggest that they give up their livelihood and income stream.

I relate the above scenarios in this introduction for a number of reasons. This thesis concerns pluralism, and the challenges of working within, and engaging with multiple medical realities. During my time in Barberton, I encountered a range of attitudes expressed by biomedical professionals opining on the plural therapeutic landscape, some who were staunch defenders of the value of having multiple healing avenues, some who were staunchly against this, and indeed many who were entirely ambivalent.

Arguments abound that patients should be allowed to follow whatever therapeutic avenue they feel is most appropriate, and to prevent them from doing so was often considered not only immoral and highly unethical, but also touched a vein of political sensitivity in a post-apartheid world in which relativism and cultural pluralism is expected to be embraced. Even biomedical professionals in my study who described African traditional medicine as the avenue of the ignorant and uneducated, knew full well that openly expressing such opinions was frowned upon.

While there is of course a deep and complex political dimension to South Africa's plural medical landscape, this should not prevent us from posing difficult questions. For example, how do we reconcile that different therapeutic systems might impede efforts to manage infectious diseases like tuberculosis? And this is not a trivial question given that South Africa is facing a burgeoning TB epidemic that is taking full advantage of a large immune-compromised population.

### *Outline of the thesis*

Chapter two outlines the literature review including an overview of African traditional medicine in South Africa and how it has been portrayed from a 'Western biomedical' context. This section also reviews the literature on proposed collaboration between systems, and the challenges and ethical considerations that are frequently raised in the literature. Public health literature regarding the interface between Western medicine and African traditional medicine is critically analysed in relation to traditional healers; biomedical professionals; and patients.

Chapter three outlines the project aims, research questions and data collection methods employed. I discuss sampling, and the various fieldwork phases, outline my analytical approach, provide an overview of the ethical review process, and reflect on negating

institutional and social access. I also provide personal observations of undertaking research in a emotionally, culturally, and politically sensitive topic.

Chapter four outlines the town of Barberton in which the project took place, and discusses the background to the town and its demographics. This section also introduces the contours of the plural medical landscape in the research site, and concludes with a thorough overview of the two hospital sites at the heart of this study, namely Barberton tuberculosis and Barberton general hospital.

Chapter five deals with Barberton General hospital and is the first of two findings chapters. The chapter presents findings on how African traditional medicine emerges within the hospital spaces, framing this primarily from the perspective of biomedical professionals. I then shift the discussion from general views on biomedical encounters with African traditional medicine to specific 'sites of concern' - i.e. the paediatric and maternity wards which are considered by nurses and doctors as 'acute' areas of concern. The latter phases of this chapter deal with the notion of nurses as brokers of culture.

Chapter six, the second major findings chapter, is dedicated to the work carried out within the tuberculosis hospital, and is similarly divided into two broad parts. The first focuses on an in-depth narrative exploration of two tuberculosis patients, and the second, examines the tuberculosis hospital as a site of incarceration in which biomedical power and control is exercised, and where dogmatic adherence to the 'legitimate' treatment avenue is policed. Chapter seven concludes with reflections on the thesis findings, and outlines potential fruitful areas of important research emerging from this work.

## ***Chapter 2: Review of Literature***

### ***2.1 African traditional medicine in South Africa***

South Africa's Traditional Health Practitioners Act of 2007 attempts to provide a regulatory framework on practitioner training and registration, and oversight on efficacy and safety of 'traditional health care services'. The act identifies four broad types of healer. The diviner (*sangoma*), the herbalist (*inyanga*), the traditional birth attendant, and the traditional surgeon. The two most common evoked in South Africa's public health literature are the *sangoma* and the *inyanga*, and I too use these two categories as a basis of discussion with participants in my research.

A distinction is often made in the literature between the practices and skills of the *sangoma* and *inyanga*, with the former defined as a practitioner of the esoteric who is able to communicate and channel ancestors, and the latter often characterised as a type of indigenous pharmacist or apothecary. A healer who does not engage in any divination, but rather has deep knowledge of the use of local flora and fauna, and how they can be used to treat and prevent illness, and promote health.

This said, my own experiences in the field would suggest that boundaries of these healer 'types' so often evoked, may have blurred. I say this as I have encountered *tangoma* who also label themselves as *tinyanga* and visa versa. Indeed many of the Swazi I interacted with in the field of Barberton made no distinction between the *sangoma* and *inyanga* – stating that they were one and the same, practitioners of the esoteric who have strong connections to the ancestors. The blurring of these terms I also note in Golooba-Mutebi and Tollman's writings (2007), and the 'White' sangoma-trained surgeon, David Cumes (2013), appears to use these terms interchangeably. Reaching back further into the literature, Enid Gort (1989), exploring the evolution of traditional healer categories in Swaziland, also observes this 'blurring' of once discrete healer roles, and further noting that where once there was a considered gendered dimension of these roles, where *tangoma* were said to be predominantly female, and *tinyanga* predominantly male (Ngubane, 1977), this may no longer be the case. The particulars of this issue are not a direct matter of concern in this thesis, apart from the fact that it highlights the challenges of defining and understanding categories, definitions, and labels encountered by field researchers. I raise this here only to demonstrate that attempts to reach for even the most basic of definitions is likely to encounter resistance. The very terms

‘African traditional medicine’ or ‘African traditional healing’ are an excellent example of poorly constructed labels, often misused and frequently misinterpreted.

Though the term *African traditional healing* is generic, and widely used in South African parlance, in newspapers and tabloids, and within academic publications, it is to a large extent misleading as a label (Ashforth, 2005; Feierman and Janzen, 1992; Gort, 1989; Luedke and West, 2006; Thornton, 2009). For a start, the term conveys an impression of a circumscribed boundary of practice that is distinctly *African*, though this is by no means the case as traditional healers have shown themselves to be adept at adopting and incorporating concepts, knowledge, and technologies from a variety of medical systems, including Western biomedicine (Marsland, 2007; Thornton, 2009). Indeed, in this context, the very label ‘traditional’ is fraught with misunderstanding, and itself emerges as an issue of speculation and inquiry in Africa, where it has been argued that colonially conceived notions of ‘tradition’ have incorrectly been applied when comparing European invented traditions with encountered African traditions. Hobsbawn and Ranger (2012) examine this, declaring such comparisons as misleading assertions by White colonists, where ‘*unlike with unlike*’ comparisons are made on issues of hierarchy, status, and culture, rules and regulations governing social order. European ‘tradition’, as argued by Hobsbawn and Ranger, was apparently marked with inflexibility and rigid recorded rules, and in encounters With African society, colonists incorrectly ascribed the self-same characteristics to a vague notion of ‘African’ tradition – inflexible rules based on some notion of age-old ideology - much in the same manner that notions of ‘tradition’ based on assumed archaic and esoteric knowledge is romanticised. Furthermore, Langwick (2008) proposes that in relation to ‘traditional medicine’, the term ‘traditional’ emerged specifically in relation to the spread of Western biomedicine in Africa.

*“...It has served as a catchall category indexing forms of healing, kinds of affliction, and types of experts that were not officially included in missionary or colonial health care. Traditional medicine, then, is all that is not modern medicine, or biomedicine.”*

*Langwick (2008) p437*

While traditional healers are undoubtedly consulted on matters of health and illness, in reality they incorporate manifold roles including those of moral steward and cultural custodian, priest, business advisor, social worker, health extension worker, psychologist, and intermediary between ancestors, spirits, and the living. Through them one can seek to influence events, allay misfortune, purchase luck or love, circumvent or protect oneself from

the malevolence of witchcraft, jealousy, and the evil-eye, and of course to define the ultimate cause of a malady.<sup>36</sup>

At the same time, whilst the term of traditional healer might be challenged on many grounds, it is nonetheless beyond doubt that healers are to a large extent seen as preserving, as Thornton suggests ‘...a sense of a distinctive ‘African’ identity in an increasingly globalized and ‘Westernized’ country’ (Thornton, 2009, p17).<sup>37</sup> And this is of particular relevance in a country which has seen a significant revival and resurgence of African identity and culture following the dissolution of apartheid.<sup>38</sup>

Thornton (2009), through his extensive studies of traditional healing within the province of Mpumalanga in South Africa, observes that knowledge and practice in the domain of African traditional healing is by no means rigid or stultified. While traditional healers purport to maintain a firm connection to an imagined historical, and arguably, a romanticised pre-colonial past, and are to some extent seen as historical conduits in a very literal sense through the channelling of ancestors via ritual and divination, at the same time they have been shown to be adept at evaluating and improving upon their therapies and knowledge<sup>39</sup>, they are also not averse to incorporating new approaches and concepts from both Western biomedicine, and other therapeutic domains (Marsland, 2007).

Though traditional healers might necessarily view themselves, and indeed project themselves, as repositories of ancient embodied knowledge passed on to them through dreams and divination, Thornton has observed that they continuously evaluate their knowledge through practice and observation, and moreover consider themselves to be a class of professional, and not necessarily practitioners marching to the drums of history<sup>40</sup>.

The *sangoma*, or diviner, is widely reported to be ‘called’ by ancestors to the profession. It also appears to be a *condicio sine qua non*, that the calling manifests itself in the form of illness. This ‘illness-as-calling’, an ancestral affliction, can only be interpreted by a qualified diviner, and upon recognition, the suffering individual is required to be inducted for a period

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<sup>36</sup> See Liddell et al (2005) for a discussion on proximate and ultimate causes of illness. For a concrete example, Green (1985) writes, that a Swazi mother may accept that her child has diarrhoea resulting from flies settling on food (proximate cause), but will also want to establish who sent the flies to do such harm (ultimate cause).

<sup>37</sup> In a sense this description also appears to relate to the business man and self-proclaimed ‘non-healer’ Zeblon Gwala, encountered in the previous chapter.

<sup>38</sup> This resurgence was made explicit with the former president Thabo Mbeki’s reference to an African renaissance. (Bongmba, 2004; Fassin, 2007)

<sup>39</sup> Indeed, my very encounters with nurse and sangoma Lamula, as outlined earlier in this chapter, are clear evidence of a healer straddling the boundaries of modern and traditional. As is the case of TrDr Ndlovu described in the foreword chapter.

<sup>40</sup> The direct translation of *ngoma*, which provides the root word for the terms *sangoma*, is drum.

of rigorous and immersive training as a *thwasana*<sup>41</sup> (Cumes, 2013; Hammond-Tooke, 2002; Reis, 2000; Thornton, 2009)

David Cumes (2013) defines the process of *thwasa*, as one of self-discovery, in which the initiate learns to communicate and connect with ancestors.<sup>42</sup> *Ngoma*, as Janzen (1995) defines it, becomes the institution through which the initiate is transformed from sufferer to diviner / healer, as they are then inducted into a healing community. Coupled with this described illness-calling, is the claim that Western biomedicine is unable to address the illness that befalls a called initiate. This is assumed to be because the source of the malady is a spiritual / ancestral affliction, a domain over which Western biomedicine is recognised to have no sway. It is not unusual to hear traditional healers recount their calling by saying that they fell ill, and ‘Western medicine’ was unable to address the problem and affect a cure, which in turn led them to seek the help of a sangoma. It appears then, that Western biomedicine, whilst being a recognised legitimate therapeutic avenue, albeit one working out-with the domain of the spiritual, is nonetheless recruited as a means of diagnostic exclusion in justifying an ancestral-calling.<sup>43</sup> Failure to comply or respond, or at the very least to placate ancestors and entreat them as to why one cannot become a sangoma following a calling, will apparently leave an individual in a continual cycle of illness, while submitting to *thwasa* will, apparently, lead to an almost immediate lifting of symptoms (Cumes, 2013).

Through a review of anthropological literature, Thornton (2009) identifies six disciplines of ‘traditional healing’ in the region of northern Mpumalanga where this particular project was carried out. These he describes as being disciplines that can be practiced both separately as well as integrated. These disciplines are:

- (i) Divination, and the use of bone-throwing (*tinhlolo*),
- (i) Knowledge of flora and fauna

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<sup>41</sup> Rycroft (1981) defines *tfwasa* as 1) the emergence or reappearance of a new moon; 2) to be reborn; and 3) to show signs of spirit possession. The rebirth metaphor of *tfwasa*, referred to with various spellings: *twasa*, *thwasa*, describes the process of being called through ones sickness and affliction, and the change in personhood undergone through this period of affliction.

<sup>42</sup> An account of the reconstruction of self through *ngoma*, and the training and graduation process, can be found in Janzen (1995), and Reis (2000). In chapter, I describe my own experiences attending an *intfwasa* ceremony.

<sup>43</sup> I do not presume to imply that all traditional healers have used Western biomedicine as a first resort to illness, merely that many I have interacted with myself, frequently recount the journey into the domain of the traditional healer, by first stating how they fell sick with an inexplicable illness that Western biomedical professionals were unable to address.



- (iii) Knowledge of ancestors and methods of communication
- (iv) Knowledge of environmental and foreign spirits, and associated rituals
- (v) Knowledge of ngoma, singing, dancing, drumming and trance
- (vi) The relationship between teacher, student, and the school of practice

Adapted from Thornton (2009)

Thornton also suggest that each discipline contains specific knowledge, and expertise by the initiate is usually obtained in one or several of such disciplines. It is apparently a rarity to encounter a sangoma with expertise in all fields.

#### ▪ ***Illness and affliction***

In her widely referenced ethnography on the Nyuswa Zulu, Ngubane (1977) suggests that to consider colds, flu, and infectious diseases as not being contained in the lexicon of indigenous healing and understanding, is itself quite a colonial position to assume. Ngubane states that illness resulting from plain biological factors are not discounted in African cosmology, and in the Zulu context is referred to as *umkuhlane* – ‘*illness that just happens*’. Nonetheless, almost all of the debate about African traditional medicine in the public health literature I have encountered, focuses on the dimensions of the esoteric, what Ngubane refers to as *ukufa kwabantu* – ‘*diseases of the African people*’.

By making reference to ‘African illness’, one is referring to illness in terms of African cosmological concepts. Within this, there are said to be several potential explanations for the cause of an illness. All of these falling into the terrain of what Western science would label the esoteric. These include:

- (i) **God and ancestors:** ancestors are said to influence the living in a variety of ways, either directly by affording protection, or indeed causing affliction, or indirectly by omission, such as by not affording guidance and protection to living descendants;
- (ii) **Spirits:** earth-bound spirits, who are not ancestors;
- (iii) **Pollution:** also referred to as ritual impurity which might occur when one comes into close contact with a phenomena considered to be ‘unclean’ or ‘dirty’ with examples that include abortions, births, illness, death and burials – *tindzaka*, discussed earlier, is a prominent example of this.
- (iv) **Witchcraft / sorcery:** the malevolence of practitioners of ‘dark’ and mischievous magic. Further explanations in this vein include illness resulting from social discord, and for example envy and jealousy.

*Adapted from Cumes (2013)*

## 2.2 *The challenge of collaboration*

It has been suggested that indigenous healers are consulted because they are thought to provide an avenue culturally appropriate healing that aligns with patient/client expectations. It has also been widely reported that such healing is patient-centred and holistic, and importantly, it accounts for, and indeed embodies, matters of a social and spiritual dimension (King and Homsy, 1997). Indeed in African cosmology, a person is said to be intimately and simultaneously connected in social, emotional, spiritual and physical dimensions (Feierman and Janzen, 1992; Ngubane, 1977; Wreford, 2005a, 2008), and of course health and wellbeing are influenced by such connections. Of course a reductionist science-leaning Western biomedical system is certainly not geared to address health and illness considering these various domains. Hence, why the socio-cultural proximity of traditional healers to patients has been a key factor in international calls for greater collaboration between allopathic and traditional health practitioners, with the most prominent of these arguably emerging from the Alma Ata accords promoting universal primary health care in which it was stated that:

*Traditional medical practitioners and birth attendants are found in most societies. They are often part of the local community, culture and traditions, and continue to have high social standing in many places, exerting considerable influence on local health practices. With the support of the formal health system, these indigenous practitioners can become important allies in organizing efforts to improve the health of the community. Some communities may select them as community health workers. It is therefore well worthwhile exploring the possibilities in engaging them in primary health care and of training them accordingly."*

*WHO / UNICEF (1978) pp. 63*

As a result of the recognition of the importance and status of the traditional healer in South African society, it has been widely suggested that the Western biomedical public health system embrace these practitioners, and engage with them to promote and expand the reach of primary health care, and in particular, HIV/AIDS and Tuberculosis treatment and education (Munk, 1997; WHO and UNICEF, 1978; WHO, 1995).

Such engagement with 'other' practitioners by a biomedical public health establishment that is seeking to expand its reach, has raised questions regarding the type of interaction or collaboration envisioned. And with a just a cursory glance at the literature, it is evident that there is a glaring and obvious lack of symmetry in the 'efforts' of a biomedical establishment to engage African traditional healers as the objective is usually the promotion of a

biomedical programme of epidemic mitigation. This raises questions of what ‘type’ of collaboration and inclusion has been envisaged, of which Freeman and Motesi (1992), consider three varieties. These include:

Figure 3: Freeman and Motesi’s models of collaboration and inclusion

<b>Incorporation</b>	<ul style="list-style-type: none"> <li>▪ Traditional healers are integrated into primary health care as a ‘first-line’ health source.</li> <li>▪ Takes advantage of healer proximity to patients in resource poor, difficult to reach locales.</li> <li>▪ Controlled by Western doctors – including referral of patients needing advanced care to Western health professionals.</li> <li>▪ Essentially become health extension workers, trained in basic curative and preventative health care.</li> <li>▪ Seen as a way to regulate / discourage potentially harmful traditional practices.</li> </ul>
<b>Co-operation /collaboration</b>	<ul style="list-style-type: none"> <li>▪ Each medical tradition remains autonomous, retaining own methods of treatment.</li> <li>▪ Recognition between Western and African medicine of the relevancy and importance of each others tradition.</li> <li>▪ Two-way referral between practitioners.</li> <li>▪ Mutual agreement on what diseases need referring.</li> <li>▪ Capacity for parallel treatment, and co-ordination between practitioners.</li> </ul>
<b>Total integration</b>	<ul style="list-style-type: none"> <li>▪ A blending of the both systems.</li> <li>▪ Treatments involves both African and Western diagnoses, and remedies.</li> </ul>

*Adapted from Freeman and Motesi (1992) pp 1184-1185*

It is evident that much of the public health literature revolving around collaboration between African traditional medicine and Western biomedicine, tentatively explores the first of these models, i.e. the ‘incorporation’ of African traditional healers into a biomedical paradigm by encouraging them to refer patients to the ‘Western’ health facilities.

Of course this particular approach has been widely criticised, not least because traditional healers claim to feel patronised and subordinated (Wreford, 2005a). Healers also complain that this approach brings them into engagement with both nurses and doctors who afford them little respect, and indeed, who view them with suspicion and no small amount of derision. And while much of the work on collaboration has been undertaken against a

backdrop of the more recent HIV and TB syndemic, views on the challenges of collaboration between indigenous and allopathic healing were voiced prior to the burgeoning of these diseases, where it has been suggested that equitable collaboration will only be realised when an apparent re-orientation of biomedicine occurs, and where the proclivity towards reducible diagnostic categories expands to encapsulate a wider, and more intricate meaning-centred approach to health, illness and disease conceptualisation. In this respect the contention is that biomedicine needs to respond to exerted socio-cultural factors in the social construction of illness (Katon and Kleinman, 1980), and expand beyond its reductive ontology. And while many appear to call for, and advocate a type of collaboration between healing avenues, where the *a priori* conjecture is made that this would be the best approach to expand essential primary health care to the benefit of the public, such assumptions have been drawn with little attention to the views of the public in this regard, prompting the anthropologist Sjaak van der Geest (1997) to call for a much needed community perspective.

### **2.3     *Exploring the therapeutic interface***

Whilst official public health provision in South Africa is delivered exclusively through a state-run biomedical health system, there have been a number of examples of interaction between the biomedical and indigenous medicine sectors, with subsequent studies that explore such interaction and ‘collaboration’. In this latter regard, there are a number of related areas of study which I will cover in the following pages. These broadly fall into investigations that critically examine:

- (i)     Traditional healers’ skills, and their potential for functioning as, what I have termed, pseudo-health extension workers.
- (ii)    Patient views and uses of different therapeutic avenues.
- (iii)   The views and knowledge of biomedical professionals on aspects of African traditional medicine and interactions therewith.

It should be said at the outset, and as a significant critical point, that the majority of these studies emerge from literature dealing with matters of public health, and, by and large, they concern themselves with African traditional healers and how they might best be incorporated into a Western biomedical treatment paradigm. And it has been popular in the last two decades to explore such collaboration with respect to expanding TB and HIV education,

treatment, and diagnosis (Chipfakacha, 1997; Homsy et al., 2004; King and Homsy, 1997; Leclerc-Madlala, 2002; Peltzer et al., 2006). In this respect, these biomedical slanted efforts rarely consider any ontological and epistemological aspects of African traditional medicine *per se*, focusing largely on the expansion of a 'Western' model of intervention.

Where this particular criticism does not apply, is to a handful of studies that emerge from the anthropological domain, where there is a greater emphasis on interrogating culture and belief, including that of the Western biomedical system. Indeed, it is within the domain of anthropology where there is a proclivity to consider biomedicine as merely one amongst a range of 'ethnomedical' systems, embodying its own unique cultural values and symbolism.

Like all ethnomedical systems, biomedicine affords us with its own unique representation of an illness-reality. (Hahn and Gaines, 1984; Hahn and Kleinman, 1983; Lock and Gordon, 1988). However, by claiming that biomedicine affords merely a representation of reality - an approximation so to speak - in no way denies that such a representation is in fact 'true' and not merely a symbolic representation of such a reality. It merely acknowledges, as Hahn and Gaines suggest, that an ultimate and true ontology cannot be known except through systems of symbolic representation, of which no such systems can lay a claim to be stripped bare of cultural baggage.<sup>44</sup>

## **2.4 Studies exploring traditional healers**

The model of 'incorporation' outlined by Freeman and Motesi above, is clearly evident in the works exploring the biomedical-traditional medicine interface. And it is through these studies that attempts have been made to explore traditional healers' views on collaboration and Western biomedicine. Whilst there are certainly numerous publications examining traditional healers and their views on collaboration in other countries, there are only a

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<sup>44</sup> There exists a rich seam of scholarship about the 'Western biomedical' systems. The decades of the 80's and the 90's in particular, saw an emphasis made by anthropologists and sociologists, and indeed those toiling in the borderlands between the medical and social sciences, to turn the lens of inquiry from the foreign and exotic healing practices of the 'other', onto biomedical territory. In their 1985 edited volume of essays, *Physicians of Western Medicine*, Robert Hahn and Atwood Gaines begin their introduction by describing the foray of social scientists into '*a new territory in the heartland of their own society*' from where '*accounts both strange and strangely familiar*' have emerged. Prominent works in this seam of scholarship include, but are by no means limited to Wright and Treacher's *The Problem of Medical Knowledge* (1982); Hahn and Gaines' *Physicians of Western Medicine* (1984); Lock and Gordon's *Biomedicine Examined* (1988), Kleinman's *Writing at the Margins* (1995), and Byron Good's *Medicine, Rationality, and Experience* (1994), with these building upon the works of prominent theorists such as Michel Foucault, Elliot Freidman, Ivan Illich, and Irving Zola. These works all emphasise the deconstruction of biomedicine as a monolithic and privileged practice.

handful of these papers directed to the South African context. Prominent among these are Colvin et al's (2003) attempts to assess the acceptability and efficacy of traditional healers as TB treatment supervisors in the Hlabisa district of KwaZulu Natal; Shuster et al's (2009) explorations of traditional healers' acceptance and views towards and anti-retroviral programme in the Eastern Cape province, with a particular emphasis on the suitability of biomedical idioms in the 'African' domain; Green et al (1995) who carried out a study and assessment of the AIDSCAP (AIDS Control and Prevention) project in South Africa, which involved training traditional healers in basic epidemiology; practices relating to HIV / AIDS; education, counselling and support, as well as issues of record keeping and confidentiality; and Mngqundaniso and Pelzer's (2008) investigation of the perceptions of nurses and traditional healers on collaboration in the matter of HIV.

Colvin et al, building upon Wilkinson et al's (1999) exploratory study, conclude that traditional healers involved in their programme may well serve as effective TB Directly Observed Treatment (DOT) supervisors, but they also highlight that the major hurdle of distrust between healers and health authorities is still very much a key barrier. They expand little on the source of this mistrust, and they fail to address what I feel is a significant point that might arise as a direct result of their study, that such programs might only foster greater mistrust as they are, in effect, entirely one-sided, and somewhat patronising given the emphasis is to examine the 'suitability' of traditional healers as DOTS workers.<sup>45</sup>

Shuster et al (2009) explore how Western 'biomedical' concepts, in particular the 'boosting' of immunity in the context of antiretroviral treatment, might well 'slot-in' to an 'African' understanding and conceptualisation of illness, and through this suggest that a more amenable collaborative approach might be possible where local idioms and understanding might be adopted. Indeed, the authors go one step further by acknowledging how, and indeed why, African traditional medicine might be seen as entirely compatible with Western biomedicine, not merely because the former might be recruited to further the reach of the latter, but also because of the different perspective afforded of each - biomedical approach seen as an effective tool in the fight against HIV by dealing with *proximate* causes of the illness, where these might well work in synergy with the African traditional healers endeavours at addressing the *ultimate* cause of the illness, the spiritual, or wider socio-cultural aspects of illness. The healers participating in the study, apparently unanimously held the opinion that antiretroviral therapy would never be able to treat the ultimate cause of HIV. The authors do, however, include the caveat that effective collaborative efforts need to

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<sup>45</sup> Indeed, as will be seen in my own work in the pages ahead, there is much cause for interrogating the suitability of biomedical professionals as TB DOT supervisors.

be built with ‘*educated traditional healers*’ who will easily recognise the need to refrain from using potentially harmful traditional treatments such as purgatives and emetics.

Traditional healers in Mngqundaniso and Pelzer’s (2008) investigation, on nurse and traditional healer perceptions on collaboration in relating to STDs, uncovered a distinct lack of trust between nurses and healer, with nurses broadly espousing negative attitudes towards traditional healers. The mistrust of healers, and the chagrin expressed by healers who are clearly cognisant of this mistrust, appears to be a common feature in much of the writings on the subject (see also Campbell-Hall et al., 2010).

Both Mngqundaniso and Pelzer (2008), and Campbell-Hall et al (2010), as well as many of the aforementioned works examining collaboration and medical pluralism, highlight that it is imperative in any collaborative efforts that biomedical professionals and African traditional healers understand each other better, to be able to foster trust and mutual respect. In this respect, I reiterate the previously stated musing by Ashforth who suggests that:

*There is no reason to presume that Africans working within the medical system as doctors, nurses, and technicians are completely severed from all cultural forms and practices of the world in which they live, nor that their professional practice and personal lives conform seamlessly with the ideological stipulations of 'scientific' medicine...*

*Ashforth (2005, p. 240)*

I argue then that these suggestions, in the wider public health literature, that biomedical professionals should concern themselves more with understanding African traditional medicine, requires more nuanced consideration. The repeated calls emanating from much of the public health oriented literature stating that biomedical professionals should foster greater collaboration with traditional healers, so as to better ‘understand’ each other, of course makes the assumption that nurses and doctors do not understand African traditional medicine, and are critically unaware of the local idioms of illness and treatment.

Indeed, the works in the wider region by Upvall (1992), Langwick (2008), and Barbee (1987), as well as the medical historians Digby and Sweet (2002), examine the position of nurses as brokers of culture, professionals who aren’t ideologically wed to a Western biomedical model, but who rather straddle the overlapping terrain of African traditional medicine and Western biomedicine, which itself brings into question what we mean by a biomedical professional. Before launching into this, however, there is a small body of literature dealing with biomedical practitioners’ views on African traditional medicine and collaboration.

## 2.5 *Studies exploring biomedical professionals*

There is very limited literature examining the views of South Africa's biomedical professionals on issues of African traditional medicine – and this thesis, in part, aims to expand this. Empirical studies that do exist usually revolve around the examination of nursing, and to a much lesser extent doctors' views, with respect to African traditional medicine, and these largely appear to convey an impression of biomedical professionals as being suspicious, and disapproving of the practice and practitioners of African traditional medicine.

Nurses participating in Mngqundaniso and Pelzer's (2008) study, emphasise the lack of standardisation of traditional medicines, the absence of any valid scientific testing used in the practice, with criticism extending beyond this to the management of patients where traditional healers are also criticised for not maintaining patient records of any kind, and where the 'system' of traditional healing does not control for dangerous charlatan healers.

Sumaya Mall's (2005) examination of doctors' and nurses' attitudes towards traditional medicine evidenced these professionals concerns that traditional healers would undermine antiretroviral programs, and cause harm to patients in two ways. The first being the provision of traditional remedies that might adversely interfere with HIV medications – usually through an alteration of patient metabolism, and the second through a behavioural route, where it was suggested that healers might in fact delay patients from timely health seeking, or indeed that patients might be encouraged to substitute Western for traditional treatment. Much the same criticism of African traditional medicine arise in Campbell-Hall et al's (2010) study. Interestingly, what emerges from Mall's study is an impression of biomedical practitioners who feel like they are sidelined by African traditional healers who actively, and in their view inappropriately, influence patient beliefs and attitudes, which, perhaps unsurprisingly, is the selfsame complaint held by African traditional healers.

It is in the already mentioned works of Upvall, Langwick and Barbee, as well as the medical historians Digby and Sweet, in which we can find a more critical, and I would argue a deeper perspective of how African traditional medicine and Western biomedicine articulates, specifically within biomedical spaces. These works specifically examine the role of nurses as brokers of culture and cultural change, though the only one of these works to be undertaken within the South African context, is Digby and Sweet's historical piece examining the position of nurses as brokers of culture during the colonial period of South Africa's early mission hospitals.



The notion of the nurse as culture broker takes a far more critical view on the cultural commitments and obligations of nurses, where far more emphasis is placed on interrogating the biomedical institution as a monolithic and inflexible structure. Indeed, much of the literature on the collaboration between African traditional medicine and Western biomedicine emerging from the public health domain is lacking in such a perspective, where it is almost considered by default that such institutions are staffed by biomedical-ideologically driven individuals. Langwick, Upvall, Barbee, and others illustrate that this is certainly not the case, with a far more fluid and flexible relationship between nurses and patients, and where the therapeutic nexus is governed by complex negotiation that accounts for beliefs. Whilst much of the literature calls for biomedical professionals to become more attuned to the beliefs and views of their patients, the small literature on the culture brokering role suggest that biomedical professionals are already attuned to such beliefs, as they themselves derive from the same cultural and social context as their patients. This particular aspect is explored in this thesis. For issues of integration, I have threaded a critical overview on the culture-broking literature, including the works of Upvall, Langwick, Digby and Sweet, and Barbee, directly into chapter six.

## **2.6     *Studies exploring patients***

Studies investigating patient views on the uses of different therapeutic avenues fall predominantly under explorations of ‘health seeking behaviour’ and ‘patient beliefs’, and how ‘beliefs’ on the relative values of different therapeutic avenues might influence behaviour.

In South Africa, a significant proportion of this literature revolves around tuberculosis treatment adherence and control. Numerous authors observe that our attempts to control TB need to move beyond a mere emphasis on improved chemotherapy, and ever more sensitive diagnostic tests, as often neglected complex social and cultural factors need to be better understood (Edginton et al., 2002; Rubel and Garro, 1992). In short, an understanding of patient motivations with regards to health seeking is said to be critical for the effective treatment of a disease such as tuberculosis.

Steen and Mazonde (1999, 1998) working in adjoining Botswana, and investigating health seeking behaviour and attitudes and beliefs of tuberculosis patients towards their disease, emphasise the complexity of TB treatment where patient motivations are not well understood, and where patients attempt to frame the origins of their malady in terms other

than that of the Western biomedical paradigm. In this, they emphasise the shortcomings of a Western biomedical model that provides patients inadequate, or perhaps limited, explanation for the origins of TB affliction. In this, they evoke the challenge of these articulating health systems, one system providing a *proximate* cause of the TB affliction, being *mycobacterium tuberculosis*, and the other providing answers to the potential *ultimate* cause, which essentially addresses the sufferer's much broader and arguably more philosophical question - *Why me?* An explanation on which the biomedical health sectors is of course not equipped to opine, though this is a question over which the traditional health sector claims sway.<sup>46</sup>

That there is movement across and between different healing avenues, is of course a central feature of these studies, and it is widely assumed that African traditional medicine is the first port of call for many patients (Mngqundaniso and Peltzer, 2008).<sup>47</sup> Indeed, it is often implied that the avenue of African traditional medicine open to patients, results in delayed presentation to hospitals for serious and complex diseases. Indeed, many of the studies that encourage traditional healers to 'learn' about symptoms of AIDS and TB, and further encourage them to then refer patients to hospitals, are conducted on the premise of quickly intercepting patients when symptoms appear, and it was assumed that traditional healers who were equipped with the 'right' knowledge and skills, would be able to help decrease the time delay to a diagnosis and treatment commencement.

While it has been suggested that patients who resort to African traditional medicine before going to a biomedical facility may risk complications from treatment delay (Barker et al., 2006; Edgington et al., 2002), it has been noted by Pronyk et al (2001) that a far more significant and substantial delay to patients, may not relate to belief and culture, but to the failure of clinical services to adequately identify symptomatic individuals on presentation in the first place. Pronyk et al's research on health seeking behaviour of a cohort of 298 TB patients in south Africa's Northern province noted that one quarter of the respondents had consulted a traditional healer, with an estimated fifty per cent of these consultations apparently happening after initial presentation at a clinic, which in turn implies an inappropriate or inadequate investigation of the patient. Indeed, apart from these factors,

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<sup>46</sup> Interestingly, Steen and Mazonde touch upon a traditional disease known as *thibamo*, which they suggest is a disease that might often be conflated with TB. (see also Haram (1991) and Livingston (2005)). In this respect, this 'African' disease concept discussed in terms of an affliction of 'pollution' bears remarkable similarities to that of *tindzaka* I encountered in my own research site, and the aetiology of which are similarly said to be a result from a moral delict. The only other instance of the conflation of TB with *tindzaka* that I encountered in the literature, was a minor note from the work of Edgington et al (2002).

<sup>47</sup> Indeed, this very claim is said to be somewhat irritating to traditional healers who are aware that it is often expressed by nurses when describing patient movement between the traditional and allopathic sectors (Mngqundaniso and Pelzer, 2008). The assumption being that a subsequent use of the biomedical sector, brands the traditional sectors a failure.

Rowe, et al (2005) highlight the many other factor affecting adherence to TB medication, including stigmatisation, lack of money for food and transport, and the disinclination to continue with TB treatment once the sufferer has become asymptomatic.

That TB treatment is complex is by no means under question, though while the above studies do illuminate the complexity of this issue somewhat, there is no study that I have come across that examines how African traditional medicine and Western biomedicine collide within the controlled spaces of a tuberculosis hospital which contributes in part to my exploration of Barberton tuberculosis hospital in this vein.

Van der Geest (2004) argues that hospitals are not identical clones of a monolithic and pan-global biomedical model, but rather that hospitals assume different forms and functions in different societies and cultures. His observation that 'biomedical' views take different forms in different places challenges much of the literature already described herein, and aligns with the literature which examines nurses as brokers of culture, and while I do not claim this to be a work in the vein of a strict ethnography, the reasons of which are elaborated in the following chapter, nonetheless, this work is informed by this theoretical stance.

## ***Chapter 3: Project Aims, Research Methods, & Reflections***

### ***3.1 Chapter overview***

Part 2.2 begins with a summary of the project's aims and research questions. Part 2.3 outlines the various data collection and research methods applied during this project. This includes the use of observations, and narrative, formal, and informal interview techniques, as well as a reflection on the value of using multiple data collection methods. Part 2.4 outlines the sampling and recruitment of participants in both research sites, and part 2.5 outlines and explores the four fieldwork phases undertaken. In this, I detail the prominent findings emerging from each phase, and how these ultimately shaped the trajectory of the project. Part 2.6 outlines the analytical approach, and 2.7 presents observations of the process of ethical review and approval. 2.8 is dedicated to a variety of in-depth reflections of the fieldwork process, such as aspects of negotiating institutional access; trying to attain social access; the challenges of undertaking research in a politically and culturally sensitive topic; and a reflection on the primary epistemological positions presented by this work, and of course my own position in relation to this. 2.9 concludes this chapter.

### 3.2 *Aims and Research Questions*

This study aims to explore how African traditional medicine and Western biomedicine articulate in biomedical institutions in the town of Barberton, South Africa. I explore this interface between African traditional medicine and Western biomedicine through (i) confined tuberculosis patients, and (ii) biomedical professionals - predominantly nurses and doctors in two research sites, Barberton Tuberculosis Hospital, and Barberton General Hospital.

Broadly defined research questions developed in the early stages of the project were as follows:

- What are the perspectives of nurses, and doctors of the plural medical landscape and the articulation of African traditional medicine and Western biomedicine?
- What are the perspectives of hospital-confined tuberculosis patients on the plural medical landscape and the articulation of African traditional medicine and Western biomedicine?

There were four fieldwork phases to this project (these are outlined in greater detail at a later stage in this chapter), with each successive phase followed by an analytical and reflective period in Edinburgh.

As successive phases of the research were conducted, and a more nuanced understanding of the field was developed, research questions became further refined. Specifically, following phase one and two of the study, two further research question were added, the first dealing with the creation of a 'typology of collision' – i.e. exploring nurses and doctors views on the ways African traditional medicine is said to arise in hospital spaces:

- How does African traditional medicine arise in Barberton's hospital, and what are the views of nurses and doctors on how this should be confronted and managed?

The second of these more developed research questions is also broad, and more methodologically inclined.

- What are the views of hospital-confined TB patients on the plural medical landscape? How might patient journeys through a plural medical landscape be explored through narrative?

There are two other significant refinements to the above lines of inquiry. The first of these emerged through general observations and discussions with employees and patients in

Barberton's tuberculosis hospital. This concerns observations of the TB hospital as a site of power and control. The second refinement relates specifically to nurses, and arose following phase two of the project where I began to consider not only the views espoused by nurses, but the different ways they were presenting themselves as mediators between doctors and patients. This evolved into a further research question.

- How do nurses position themselves as brokers of culture within the plural medical landscape?

It is also important to note that the above evolution of research questions was shaped by observations, interviews, and discussions, as well as a continuous exploration through the literature in medical anthropology and public health. While the preceding literature review deals primarily with broad aspects of medical pluralism in South Africa, the literature concerning these further evolved and developed research questions, are included in the relevant findings sections.

### **3.3      *Research Methods and Data Collection***

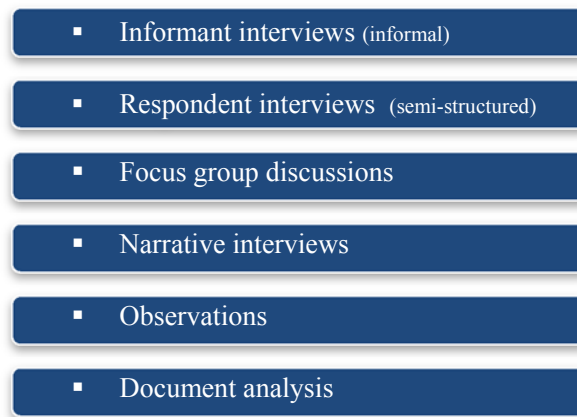
The word *organic* probably best describes the fieldwork process for this thesis, although *chaotic* would certainly be a close competitor! On more than one occasion, avenues of inquiry that I suspected would be fruitful hit an unexpected and sudden dead-end, to be replaced by novel avenues entirely. This organic characteristic was not restricted to the evolution of themes within this project, but permeated throughout, influencing my data collection, my application of different research methods, and even shaping my very path through the social, cultural, and institutional landscapes of Barberton and its state-run health facilities.

While writing up this chapter, I did consider limiting this section to only describing the methods that proved successful. After all, there is in the academic-universe a general proclivity towards emphasising what did work, rather than what failed to work. Were I to only focus on the methods used successfully, I feel this would be a superficial representation of my fieldwork, and would not illustrate the complexity of the undertaking.

What follows is a brief overview of the methods I considered employing at the start of this thesis, followed by a discussion of each of these individually. I explore the use of each method, covering what worked, in what context, and reasons for discarding

particular methods. The combination of methods I envisaged employing at the project outset were the following:

Figure 4: Proposed Research Methods

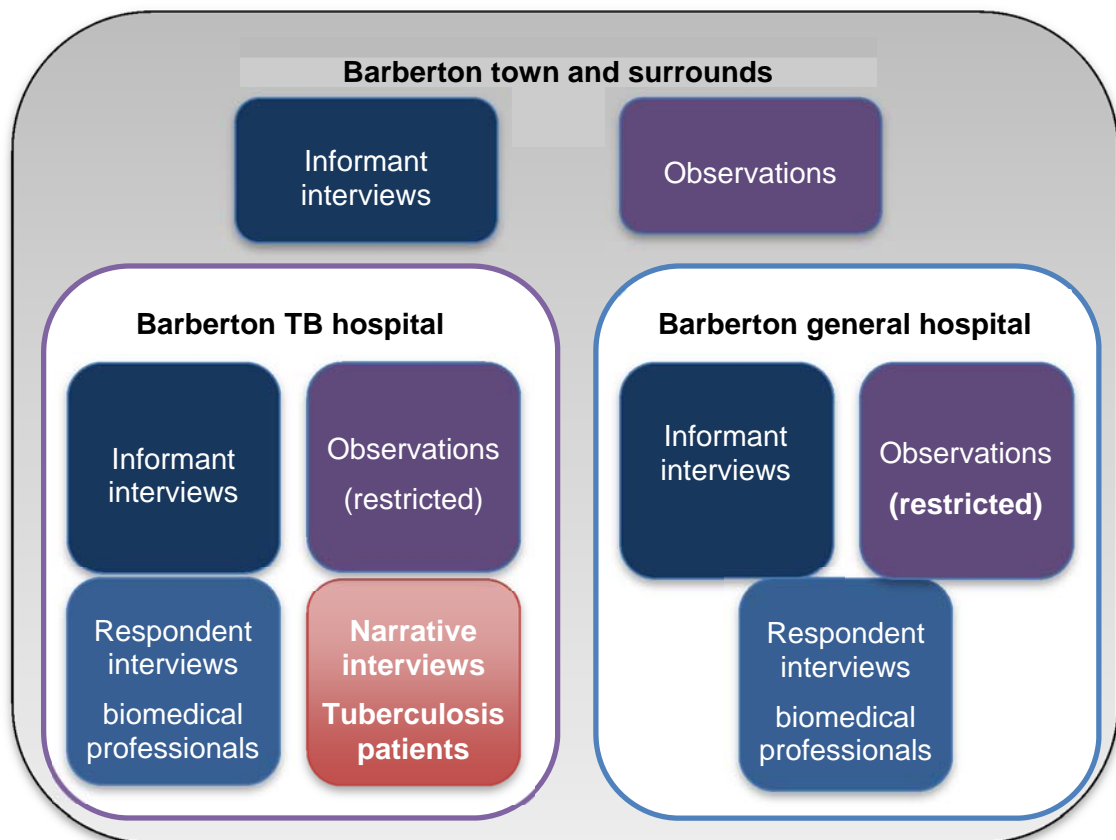


I was aware at the project outset that there would be impediments in my attempts to apply all of these methodological approaches, and that, as the project progressed, I would need to develop my approach to focus my attention on a few of these. Upon negotiating entry with institutional gatekeepers, I spent some of my time examining the relevance and potential use of each methodological approach. My ideas about the appropriateness of methods ultimately had to be balanced with what institutional gatekeepers deemed appropriate and permissible.

The following illustration is an indication of the methods I did end up applying, the research sites in which they were applied, and the participants they were used with. What emerged at the end of the project was a multi-layered fieldwork experience in which I found certain methods useful in very specific contexts.

As can be seen below, focus groups and document analysis have not been included in the illustration, for the very reason that they played very little role in the end due to challenges of either access, or arising ethical dilemmas – I discuss the reasons for this in the forthcoming pages.

Figure 5: Application of Methods in Research Sites



### 3.3.1 Informant interviews: used extensively

In my use of the term informant interviews, I evoke Powney and Watts' (1987) typological distinction between participants who are informants and those who are respondents. The informant interview process can be best characterised as unstructured and flexible, where there is limited control over the interview direction by the researcher. There is a good deal of symmetry between the concept of the informant interview and what Gobo (2008) describes as the discursive ethnographic interview.

This interview approach is used in a context where a researcher aims to deeply immerse him or herself into a defined area (Bailey, 1992; Hammersley and Atkinson, 1983; Neale, 2009) and is considered different from other forms of interpretive research methods with the claim that insight rendered is potentially far richer than the detail that might emerge from, for example, the sole undertaking of more formalised and structured interviews (Gobo, 2008).

Informant interviews were predominantly held in English, with a smattering of Afrikaans, and I approached them as natural and reciprocal conversations, both asking and responding



to questions where, as Bailey (1992, p. 7272) suggests, they serve a useful mode to '*share feelings, impressions, ideals, and information*'.

Unlike the manner in which respondent interviews were approached – in which a specified date and time were negotiated and where the discussion was influenced by structure and a clear distinction between interviewer / interviewee roles, informant interviews were far more impromptu, often occurring over several periods, and serving as opportunities to build relationships. I draw from Gobo (2008) and Robson(1997) to outline the characteristics of this interview approach, and how they apply in the context of my own fieldwork.

- The informal approach was useful when first entering the field, particularly when negotiating institutional and social access, building up networks, and ascertaining the relevancy of the research questions and proposed methods.
- The informant interview was never recorded on tape. On a positive note, this meant there was one less barrier between myself and informants, but this also meant I had to rely far more on structured field notes to capture impressions, which over a long discussion can be challenging.
- This approach was also useful in encounters when I had already established a history and rapport with an interviewee, and thus a more open, and two-way discussion could be had in an atmosphere of familiarity.
- Interviews had no standard timeframe, as I did not use a defined interview schedule. Some of these interviews would last a few minutes, while some would last over an hour.
- Interviews were rarely scheduled, and were usually impromptu discussions, often to explore or delve deeper into unfamiliar concepts, or to cross-reference emergent themes.
- Usually several interviews occurred over time with the same individual, and thus there was an evolving relationship and familiarity. This helped significantly as with the 'unpeeling' of layers, one can obtain a more intimate understanding of individual perspectives.

Prior to entering the field, I assumed that the value of informant interviews would lie mainly in the early fieldwork stages, where a softer approach to negotiating institutional and social access was required. I also assumed that this approach would help me to ease into, and familiarise myself with Barberton town and the biomedical facilities therein. Following this, I proposed to launch into applying and relying on more structured schedule-driven respondent interviews with selected participants.

However, as it turned out, informant interviews were integral throughout the study. In the true ethnographic vein, this approach would run parallel with the central pillar of the ethnographic method, participant observations, and be used to assist the ethnographer to delve deeper into elucidating meaning and behaviour relating to observations (Gobo, 2008). However, my suggestions on using observations were resisted by hospital gatekeepers who

were concerned about the implications for patients and practitioners who were unwilling to be observed.

Informant interviews proved integral to: illuminating the contours of Barberton's therapeutic landscape; negotiating access to facilities and individuals; determining what lines of inquiry might be relevant and the manner in which to go about exploring them; and identifying key individuals who would be able to assist in my efforts. They were useful not only in exploring emergent contextual themes and trying to understand the meaning of concepts encountered, but also in helping me to navigate the physical, social, and cultural dimensions of the research area.

I cast the net wide in my use of informant interviews and held conversations with a diverse range of individuals. From town residents at Emjindini taxi rank while waiting to catch a ride to the nearby town of Nelspruit, to business owners, employees, and townspeople I had gotten to know over the weeks and months. Of course they were also used extensively with a wide range of hospital employees including doctors and nurses, administrators, managers, cleaners, gardeners, security guards, and patients.

### ***3.3.2 Respondent interviews: used extensively***

Powney and Watt's description of respondent interviews, when compared with informant interviews, is that there is a great deal more structure surrounding the former. Respondent interviews are essentially semi-structured interviews guided by a pre-designed, though evolving, interview schedule (see appendix 1). Respondent interviews were limited to the two biomedical institutions, and were only carried out with biomedical professionals, nurses, doctors, occupational therapists, and trainee nurses.

While I characterize these as being more structured, I do not mean to imply that respondent interviews were rigid and inflexible. Interview questions were open-ended, and participants were encouraged to respond openly, freely, and as they felt necessary. I encouraged participants to narrate experiences, and would actively adapt the interview schedule, both the order of questions and the manner in which I would ask them, in response to how the interviewee interpreted and navigated the questions. The following points summarise some of the primary characteristics of the respondent interviews, and as can be seen, there are clear contrasts with informant interviews:

- Respondent interviews were always held within the specific locations of Barberton General and Barberton Tuberculosis Hospitals, and usually in private offices or unused clinical spaces

where we would be undisturbed.

- Respondent interviews were targeted to a very specific group of individuals – only doctors, nurses, and allied professionals.
- These interviews would usually be the only interaction I would have with a particular respondent (i.e. not longitudinal), though a few respondent interviews did develop into informant interviews at a later stage.
- The digital recorder was present and always visible during the informant interview.
- It was requested by management that each interviewee approached, should be shown both the Mpumalanga Department of Health's, as well as Barberton Hospital's letters authorising the study.
- The locus of control – to commence, navigate, direct, and close the interview – largely rested with myself as the interviewer.
- Each respondent interview began with a ritual that included a project overview, a statement of interviewee rights, and the signing of a participant consent form (see appendix 2). To all intents and purposes this meant the interview commenced with a formal contractual agreement.

Despite my intentions to ensure respondent interviews were semi-structured, allowing individuals the space to interpret and respond as they saw fit, in reality, there was a great deal of formality governing these interactions. An atmosphere in which individual and professional roles were emphasised – a White, relatively wealthy and educated researcher speaking to professionals, and exploring professionally informed views within a defined clinical space.

While I do not suggest that these elements are entirely absent in informant interviews, I would argue that they are accentuated in respondent interviews. I felt that the longitudinal aspect of informant interviews, and the opportunity to build rapport therein, allowed the overt interviewer / interviewee roles to recede into the background somewhat. During respondent interviews, the researcher – respondent relationship was constantly on the surface. Though it might appear that I am privileging informant over respondent interviews with these criticism, I merely suggest the different circumstances and different contexts require different methodological approaches, and that all approaches have attendant pro's and con's.

While I recognise the contribution and value of informant interviews to my wider research objectives, respondent interviews were designed to be targeted to a very specific audience – biomedical professionals. I wanted to explore with these individuals a much narrower set of research question relating to medical pluralism, and their experiences in dealing with aspects of African traditional medicine within hospital spaces.

The use of a more standardised interview schedule was designed to elicit responses that would be easier to compare analytically given that individuals would be responding to questions on predefined themes. Robson (1997) highlights some of the benefit of utilising a more structured interview approach, including benefit of the standardisation of interview encounters that can lead to easier analytical comparability.

Furthermore, a more formalised approach was also considered more valid and desirable by hospital gatekeepers with whom I had to negotiate institutional entry. In some of our initial negotiations, it was even suggested that I alter the study entirely, and develop an even more formalised approach by distributing self-administered questionnaire with multiple-choice and Likert scale responses. This suggestion was understandable as hospital managers emphasised their concerns about the time investment staff would have to make to undertake interviews. In these early negotiation phases I would frequently have to justify why a self-administered questionnaire was not appropriate to the study aims.

### ***3.3.3 Narrative interviews: used minimally and only with TB patients***

Narrative interviews deviate markedly from other qualitative interview approaches used in this thesis as they grapple primarily with stories. This approach moves beyond the standard questions-answer scheme of the informant and respondent interviews, and instead allow space for the story-teller, in this case confined TB patients, to relate their experience in a manner of their own construct.

In this project, narrative interviews were conducted only with patients confined in Barberton Tuberculosis Hospital. Through these narratives, I explore individual accounts of illness experiences, from illness-recognition and the subsequent journey for explanation, understanding, and treatment through various therapeutic avenues, to the events that ultimately led participants into the confining institutional embrace of Barberton TB hospital. These stories fall under the popular genre of illness as narrative (Hydén, 1997).

Mishler (2005) highlights two theoretical positions to the use of narratives in social research, the naturalist (realist) approach, in which emphasis is placed on the content of narrative accounts providing rich description of people and their social and cultural worlds, and the constructivist (ethnomethodological) approach which focuses on the manner in which social order, or impression thereof, is created through the process of narrative construction and interaction. In the realist approach to narrative interviews and analysis, focus is placed on peoples experiences, what happened to them, what the events meant to them, and thus emphasis is placed on the content, i.e. what is said, whereas in the ethnomethodological

approach, more emphasis is placed on how things are said, and thus the interview interaction itself becomes a topic of discussion.

It is arguably necessary to outline how narrative interviews compare and contrast with respect to informant and respondent interviews. In his widely referenced text on narrative interviewing, Mishler (1986) suggests that in many qualitative interview approaches, participant narratives are often restricted and suppressed, particularly where a more two-way interactive discussion is the norm. In the first instance, interviewee responses are often restricted to the delimitations of short statement-responses, and in the second the interviewer may inadvertently be interrupting narrative accounts when they do arise. Furthermore, those engaged in the domain of narrative analysis also criticise certain qualitative interviewing techniques for treating respondents as ‘epistemologically passive... mere vessels for answers’ (Elliott, 2005 p. 22), whereas a primary purpose of narrative interviews, is for the interviewer to place emphasis on stimulating a respondent’s own interpretive abilities.

In terms of conducting the actual interviews, there are clear differences with other qualitative interview approaches used in this thesis. Specifically, during the narrative interviews with tuberculosis patients, efforts were made to resist interrupting the participant’s story arc with questions and requests for elaboration. Rather than verbal encouragement during interviewing, an emphasis was placed on using non-verbal signals, and conveying attentive listening. This differs significantly from respondent and informant interviewing where more discursive two-way interaction is the norm.

A question one might consider is why conduct narrative interviews only with tuberculosis patients? Why not nurses or doctors as well? Quite simply, I was interested in exploring the very illness experience of what it was like to have tuberculosis. Illness is an embodied experience, an affliction which alters one’s physical, and indeed social, constitution. The illness experience is temporally significant, particularly as I was interviewing patients in the process of receiving treatment within a confining physical domain. The respondent interviews with nurses and doctors were geared to exploring a completely different strand of inquiry, i.e. a focus on views on medical pluralism from the perspective of professionals.

#### ***3.3.4 Focus group discussions: discarded almost immediately***

Only three prearranged focus group discussion were held before I discarded using this approach. Each had between four and six individual participants, all nurses, and the discussion was guided with the help of a scheduled set of topics. The purpose of this approach was to use group dynamics to stimulate discussion and explore the issue of medical

pluralism and the management thereof within hospital spaces (Bowling, 2005). Key reasons for discarding the use of focus group discussions are outlined below:

- Participants were reluctant to talk about aspects of medical pluralism, particularly African traditional medicine, within a group. While I tried to foster group discussion, there was often little or no group engagement and interaction. Often, there was deferment to one or two individuals who appear to have silently been chosen as dominant spokespersons who would voice a view that would usually be agreed upon by others with a nodding of heads.
- Participation was voluntary and people were invited to participate. However, for at least one of these focus groups I suspect that a number of participants were 'asked' to participate by a manager who I know was more enthusiastic about the research topic than her junior staff.
- Following these group discussions that elicited only relatively superficial information, I often had the opportunity to talk to some people on an individuals basis both formally and informally. Through some of these follow up discussion, it was clear that many people were reluctant to voice their views on African traditional medicine amongst colleagues. Some because they did not want colleagues to think they believed in, and used, traditional medicines themselves, and others because they did not want colleagues to know their very negative views on the practice.
- The final discussion, started straying into an area where it was clear that tensions between participants were being raised. I ended this focus group discussion early.

Given my focus on elucidating the views and perspectives of medical professionals who had to work together as a team, I considered it unwise to continue trying to use a research approach that might raise significant tensions between colleagues. Not only did I feel that it was unethical for me to be having such an effect of upsetting the balancing of professional relationships, but it was also clear that some of these participants were not well disposed to me because of the event at the focus group, and as a result did not want to participate any further. With respect to nurses who were deferred to as spokespersons of sorts, I now feel like they were silently chosen, or took it upon themselves to attempt to mediate discussion so that no controversial and contentious views would be raised, this done in effect trying to maintain a harmony.

While I may have suspended the use of formal focus group discussions, one thing that did clearly emerge from the handful held was that there certainly is a vein of conflicting ideology within hospital spaces. A vein of tensions that sits under the surface, and is not usually disturbed by formal discussion. However, to understand the vein of contentions I had encountered, one must consider the post-apartheid atmosphere where cultural tolerance is effectively demanded, where respect for cultural and moral relativism is sacrosanct. One junior nurse within the a focus group discussion eventually forwarded the following point. She was young, only in her mid twenties, and only recently qualified as a professional nurse.

Up until the following words she had not contributed to the discussion with five of her colleagues.

*But are there not laws now that say it is legal [read: permissible by state sanction] for [traditional] healers to practice? So we cannot say this is right or this is wrong even if we disagree and we know, we cannot say for certain they [traditional healers] are wrong?*

*Nurse Moropane*

In a later informal discussion with this particular nurse, she disclosed that she was completely against the use of African traditional medicine for religious reasons, describing how her Roman Catholic faith takes a dim view against those engaging in ‘esoteric’ practices.

While I did not hold any further structured focus group discussion, I did manage to have a number of informal group discussions amongst tuberculosis patients. These were generally impromptu discussions of a general nature that included their personal thoughts on medical pluralism, as well as their descriptions of life as a tuberculosis patient effectively under quarantine. In this respect I do not count these as focus group discussions of a more formalised nature, but rather a group version of the informant interview discussed above.

### **3.3.5 Document analysis: used minimally**

Document analysis in the social sciences is a wide ranging, and with some exceptions, largely un-reactive, unobtrusive, and indirect methodological approach. Magazine and newspaper articles, diaries and books, notices, letters, policy documents, as well as non-written audio and visual media fall under the rubric of documents of interest to the social scientist (Bowling 2005, Robson 1997). Apart from the obvious use of documents used to compile the preceding literature review, as a methodological approach during fieldwork, document analysis did play a role, but only in a very limited sense. My initial intent to use document analysis in the field was guided by two objectives. Firstly, I wanted to explore the history of Barberton and its state run biomedical institutions, and secondly I wanted to uncover and explore if, and how, biomedical professionals record instances of overlap with ‘other’ therapeutic practices such as African traditional medicine.

#### **▪ Barberton’s historical documents**

In terms of understanding the history of Barberton and the establishment of an official town body whose remit was public health, I was able to source a few early-published diarised accounts. The town museum holds a cache of historical media – microfiche of early

Barberton newspaper publications – from which I drew some limited impression of early Barberton society. I refer to some of these in the following chapter – a background to Barberton. This said, my use of historical data and media is very limited. I was able to track only a few diarised accounts, and a comprehensive search of the media resources in the town museum was not possible due both to a lack of resources, but also because the microfiche collection in question was not indexed.

#### ▪ **Biomedical institution records**

During interviews and discussions, nurses and doctors tentatively suggested that it might be possible to go back into hospital records and in some instances compile a rough impression of the recorded incidents in which African traditional medicine was encountered in a clinical setting, and where it was seen as clinically significant. However there were significant challenges in doing this for a number of reasons. I illustrate these challenges with two of the more frequently raised examples in the interviews.

- i. A diagnosis of hepatic stress or systemic organ failure as a result of *herbal intoxication* is recorded when it is suspected that an individual has ingested indigenous medicines. Amongst doctors and nurses, the diagnostic handle - *herbal intoxication* - now appears to be the standard proxy for adverse African traditional medicine use.
- ii. There are a number of commonly used traditional herbal remedies during pregnancy that are said to induce violent uterine contractions. According to nurses the local names for these are *isihlambezo* and *masheshisa*. Doctors and maternity ward nurses complain that the use of these unregulated indigenous remedies can potentially cause significant complications such as foetal distress, uterine rupture, & meconium aspiration

When I started to explore whether there were direct or indirect references of African traditional medicine within patient records, it soon emerged that this was not feasible for a number of reasons. Firstly, there was the impediment of a cascade of hospital gatekeepers who were concerned about letting me see patient records – despite the permission obtained from the institutions senior gatekeepers. Secondly, were I even allowed to view patients records, the man hours involved to take even a small snapshot, i.e. one year for example, was prohibitive as hospital records are entirely paper based with little indexing. Thirdly, and perhaps more importantly, proxies, such as *herbal intoxication* are very rough diagnostic labels, and, according to a number of doctors interviewed, would be a very unreliable inclusion category, as it may not be universally applied. Where some doctors might record



hepatic stress resulting from suspected herbal intoxication, others might only record hepatic stress from an unknown cause. As for *masheshisa* and *isihlambezo*, doctors frequently state that they can usually tell when someone has taken this, however this is not recorded in the birth and patient log. Thus while it was theoretically possible to stray into the epidemiological arena and compile a rough incidence of birth complications to see if there was any correlation to morbidity or mortality during pregnancy, there was no way to ascertain why such complications may have arisen, whether it might be as a result of a natural, but unfortunate course of events, something caused by traditional medicines, or indeed something caused by Western medicines.

To track the subtle footprints of African traditional medicine recorded in hospital records would have required a much different research protocol, as well as a small army of research assistants to trawl through reams of dusty paper records. Tracking down hospital documentation to explore just how biomedical practitioners record morbidity and mortality that is suspected to be associated with African traditional medicine use would have been interesting, as it would have shone a light on the medicalisation of African traditional medicine.

### ***3.3.6 Participant observation: restricted use***

Observations are central to the ethnographic pursuit, and while there was certainly a strong ethnographic dimension to this project, it was unfortunate that the participant observations that I would have liked to carry out - observations of the biomedical practitioner / patient relationship - were considered too intrusive by institutional gatekeepers. I discuss this with reference to Barberton general and Barberton tuberculosis hospital individually.

#### **▪ Barberton general hospital**

The gatekeepers of Barberton general hospital included the CEO and senior management, the latter including the managers of each division in the hospital. During institutional negotiations for the research, which revolved (and evolved) over a period during which I was in the process of obtaining study approval from the provincial government health department, discussions revolved around the use of a range of interview and observational approaches I intended to utilise. Focus groups, informant, narrative, and respondent interviews were eventually deemed suitable, however concerns were raised by doctors on my

intentions of observing patient-practitioner interaction. This was deemed too intrusive and the need to get approval from the individual biomedical practitioners as well as the patients and others within the vicinity, i.e. family members, was deemed too complex and disruptive. As it was, some individuals expressed concern that the research would intrude on valuable patient time. The message from institutional gatekeepers was firm. While supportive of the research, it was nonetheless impressed upon me to be quick, be efficient, and to not disrupt or intrude on patient care.

This is not to say that absolutely no observations were undertaken within Barberton hospital - indeed it is impossible to spend time in an institutional facility such as a large hospital and not systematically observe surrounding events – though any observations made were very limited in scope.

#### ▪ **Barberton tuberculosis hospital**

Gatekeepers in Barberton tuberculosis hospital were similarly concerned with my intents to observe patients and practitioners, however their concerns revolved more around the greater risk of my own exposure to infection as observations of the biomedical professional / patient interaction would naturally require me to work indoors, and in close quarters with tuberculosis patients.

The message from the hospital management was quite simple, I was welcome to carry out my research, to interview staff and tuberculosis patients, and to conduct any observations of the facility from the outside and within the courtyard, but for my own safety, I was advised to limit indoor exposure. I confess that while I did move through the facility, sometimes traversing these indoor spaces, it was difficult not to feel paranoid, like I was passing through an invisible miasmic cloud of suspended tuberculosis bacteria. Indeed, I recall crossing half way through a room one day and was nearly at the other side when I realised I had been subconsciously holding my breath. That said I did manage to spend much time within exterior hospital grounds, and observe how patients and staff moved and interacted within the facility.

While participant observation as a method were explicitly restricted within the institutional setting, I should not that there were many instances in which observations outwith Barberton General Hospital and Barberton Tuberculosis Hospital, that is observations within Barberton town in general, would prove to be significant.

Two significant events, which are recounted in general in the forthcoming ‘reflections’ section of this chapter, were a ritual sangoma initiation ceremony, and a recently reinstated annual Swazi festival known as *Ummemo*. Both of these events, along with other interactions within the wider community, would come lead me to reflect on the value of participant observations as a method, and in many respects, regret that I was unable to persuade hospital gatekeepers of the value of undertaking structured observations of various clinical settings that were to become of interest.

While participant observation serves as an excellent method of being able to assess peoples stated views in light of how they behave in practice – with the assumption being that these of course do always align, the benefit of participant observations outwith the hospital research sites, was garnering an understanding of local Swazi culture. This helped me develop a greater cultural awareness of the area, which in turn helped me to establish better rapport with individual participants within the hospital setting.

### **3.3.7 Field notes**

The use of field notes was integral throughout the thesis. From informant interviews and respondent interviews, to narratives, generalised discussion, and observations, field notes ‘knitted’ the entire project together. My approach to field notation did not vary much between different methods, though there were certainly different ‘types’ of notation used throughout the fieldwork. They can roughly be divided into:

- Rough mental notes taken during interviews and observations. Who said what and when. My preference in taking notes when interviewing or discussing is to use short key words in an effort to minimise disruption. These are expanded upon in my own time soon after.
- Notes on reflexive elements, and the interrogation of my own role in a particular situation, i.e. observational position, interviewer role etc....
- Reflective notes on impressions and feelings. As well as whether something said correlated with things I had already come across in the literature.
- Notes relating to structure and potential avenues to follow – i.e. emergent themes, potential people to contact, and trajectory plotting.

### **3.3.8 *Using multiple methods***

Using more than one research method is by no means unusual. As Robson suggests, it is a good way to try and minimise uncertainty by interrogating the same research questions using multiple approaches. Malterud (2001) suggests that the term ‘triangulation’ derives from land surveying, and in the social science context, the term implies that one can more robustly study a phenomenon when it is explored from a number of different angles. In this respect, it is assumed that greater confidence can be placed on the generalisability (i.e. validity) and the consistency (i.e. reliability) of findings. (Seale 1999; Ingleton and Davies, 2007).

## **3.4 *Sampling and Participant Overview***

### **3.4.1 *Barberton General Hospital***

In total, twenty-nine nurses and eight doctors drawn from across Barberton General Hospital’s departments participated in recorded respondent interviews. Participation was predominantly self-selective, though it should be noted that four nurses participated due to the urgings of colleagues.

Participating nurses self-identified as Afrikaans, Coloured, Swazi, and Shangaan, though the overwhelming majority identified as Swazi. Polyglotism was the norm, with most nurses speaking two or three languages, and all the nurses I encountered spoke either English or Afrikaans.

Though twenty-nine nurses participated in respondent interviews, this represents only a participation rate of approximately one third, as over ninety nurses were approached to participate. The primary reasons for nurses not wanting to participate appeared to be an expression of outright indifference for the topic; a clear indication that they did not want to discuss the topic because it was a sensitive issue; or because they were suspicious of myself and my intentions.

Of the eight doctors engaging in respondent interviews, two of these were Black - one a South African, and the other an immigrant from Nigeria. Five doctors self-identified as White-Afrikaans, and one doctor self-identified as a White South African, though not Afrikaans. Of these doctors, only one was a trainee recently out of university, while the other

seven lay on the spectrum from qualified and enthusiastic juniors, to senior-clinicians. Two of the doctors interviewed were locums contracted to address the staff shortage, though both had been there for longer than nine months. Fifteen doctors had been approached and asked if they wanted to participate in the study. Those that declined to participate, or indeed actively avoided participating, claimed that they were too busy. Those that did agree to be interviewed were more clearly keen to discuss a controversial issue regarding African traditional medicine within the hospital space, and indeed a self-selection bias cannot be ruled out in this respect. To what extent those who did not participate would share such sentiments, is difficult to ascertain.

Of the twenty-nine nurses interviewed, seventeen self-identified as professional-nurses<sup>48</sup>, of which four were managers with limited clinical responsibilities<sup>49</sup>, and two were managers who are engaged entirely with administrative duties, no longer engaging directly with patients. This includes the hospital's then CEO. Of the seventeen professional-nurses, three are also nursing-lecturers<sup>50</sup> who work in the on-site school that trains an annual cohort of junior staff-nurses.<sup>51</sup> Of these staff nurses, seven qualified staff-nurses, and five trainees participated. Importantly, one of the professional nurses interviewed was also a qualified *sangoma*.

Figure 6: Summary of Nurse Participants

29 nurses				
17 professional nurses			12 staff / trainee-staff nurses	
6 managers - 4 with limited clinical responsibilities, and 2 entirely administrative	3 nursing lecturers	8 practicing nurses of varying grades and experience	7 staff nurses	5 trainee staff nurses

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48 Professional nurses are those with diplomas or qualifications of at least two years in length. There is a clear hierarchy within the nursing body, and a number of nurses who were professionally qualified would go out of their way to make sure I understood the distinction.

49 Practicing managers head up teams or departments. While they do still engage in clinical work with patients, their roles include a large degree of staff management and administration

50 The nursing lecturers I interviewed, no longer engaged with patients and clinical work.

51 Staff-nurses are drawn predominantly from the community, and are usually trained in a one year qualification directly in the hospital's own teaching unit.

Along with respondent interviews, I draw from more than two dozen informant interviews with junior managers, nurses, social workers, administrative staff, doctors, and other staff of varying positions in Barberton general hospital. The parameters for sampling of informant interviews was, as is evident, far broader than for respondent interviews, with the only requirement being that informants be employed in Barberton general hospital.

Informants can also be broadly, but not exclusively placed into two types, those assisting me to navigate that physical and social space of the hospital itself and were integral in helping me to understand the nuances of the institution.

The second group were those participants who acted as informants specifically about the project topic of medical pluralism, i.e. directing me to consider spaces in the hospital that would be appropriate to study in relation to the emergence of African traditional medicine. These informants usually had particularly strong view on the collision of African traditional medicine and Western biomedicine that they were reluctant to discuss in a more formal capacity in a recorded respondent interview.

### **3.4.2 Barberton Tuberculosis Hospital**

Eight patients, out of a total of twenty approached, agreed to share their narratives with me, or at least attempted to. Four of these patients, who tried to convey stories, were unable to do so with any significant structure, or temporal coherence. While they responded to questions and prompts, it was clear that their individual abilities to craft a story of their illness journey was beyond them at that point in time.<sup>52</sup> The ability to convey a narrative account is only possible once a person is able to progress beyond this 'chaos', and reflect on their disposition.<sup>53</sup>

Of the four remaining patient narratives, each was analysed thematically, though only two are presented in detail in the relevant findings chapter. My decision to limit these case studies, I confess, was a pragmatic one. Firstly, a thorough case study of an individual narrative account is a particularly wordy affair. Secondly, of the four patients who conveyed a structured narrative, only these two acquiesced to a follow up interview, and thus I have a

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<sup>52</sup> The reason for this, I concluded, was that these patients were still very much ensnared in what Arthur Frank has labelled the chaos narrative: "*the anti-narrative of time without sequence, telling without mediation and speaking about oneself without being fully able to reflect on oneself*" (Frank, 1995, p. 98).

<sup>53</sup> Individually, these four were relative newcomers to the facility, having been resident for between two weeks to one month at the time our paths crossed. Each were still struggling to deal with their newly defined status. Coming to terms with what this meant about their individual selves, and coming to terms with the stretch of institutional confinement lying ahead.

much stronger rapport, and a more nuanced and deeper insight into their personal accounts. Note that in the subsequent parts of this chapter following the narrative case studies, all patient voices emerge.

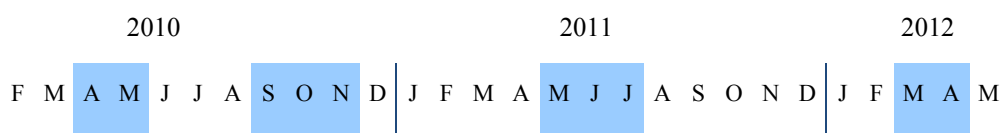
Of the staff in Barberton Tuberculosis Hospital, eleven participated, this including a senior manager / administrator, two nurse managers, an occupational therapist, and seven nurses of various grades. This represents less than half of the twenty five staff approached. The hospital has a very small contingent of nursing staff, and at the time was, and I suspect still is, struggling to operate at less than a fifty per cent staffing level.<sup>54</sup>

Apart from the narrative and respondent interviews, I also undertook a dozen informal interviews that took into account the views of the facility's on-site physician, patients, nurses, guards, gardeners, and various individuals associated with the tuberculosis hospital. Selection of these informal interviews was purposive based upon very simple criteria that individuals either worked within the TB hospital, or were resident with the TB hospital as patients.

### 3.5 *Fieldwork Phases*

Data collection took place over a period of roughly two and a half years, with a total of nine months spent in the field. The bulk of the fieldwork was spread over three phases between March 2010 and July 2011 and a brief fourth phase held over March and April 2012 (see figure 9 below).

Figure 7: Fieldwork phases highlighted numbered in blue



<sup>54</sup> Many more interviews were scheduled to be held, however, a bicycle accident mid-way through phase three of the fieldwork curtailed my research.

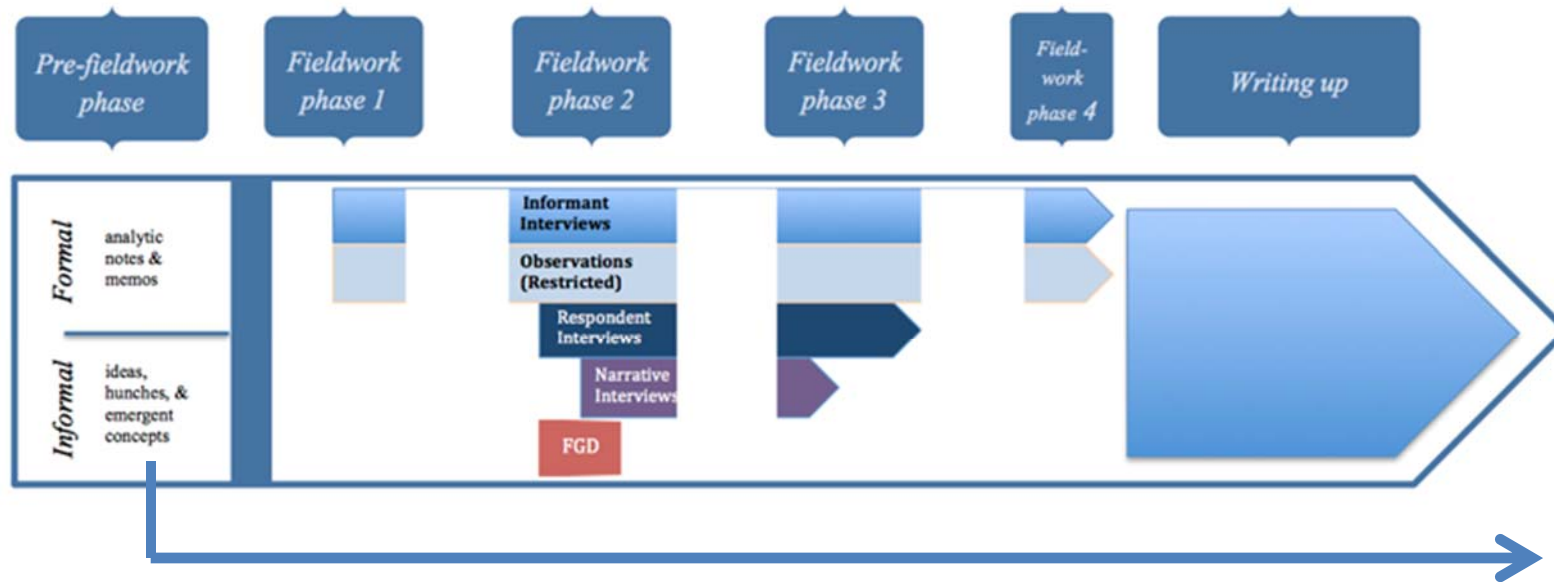
With the exception of the final fourth phase, which lasted only three weeks, each phase lasted between two to three months in length. The fieldwork phases were staggered for various reasons including:

- So that I could take the opportunity to regroup after each phase to review and analyse collected materials and data
- To identify emerging and evolving themes and to further refine and develop my research questions
- To re-evaluate the trajectory of the research as it unfolded.

Furthermore, while it is common that those engaging in immersive research take a significant period of uninterrupted time spent in the field, personal circumstances prevent me from taking this avenue.



Figure 8: Fieldwork Phases Illustration



The above illustration attempts to convey a sense of the fieldwork process, and the various methods applied at specific phases. The analytical aspects of the research did not begin following data collection, but rather commenced at the beginning of the project with formal and informal ideas, and continued throughout, shifting, and altering as new data, ideas, and lines of inquiry emerged.

### ***3.5.1 Fieldwork phase one***

In phase one of the project I gained access to the field area with the assistance of Professor Robert Thornton from the University of the Witwatersrand, and began exploring whether the town of Barberton, and the public health institutions therein, would be suitable for me to carry out my research. This included exploring the following: whether the broad outlines of my proposed research questions were of relevance to the area; whether institutional gatekeepers were receptive to the study; and also, how I would navigate the practicalities of carrying out the study which included identifying and obtaining the necessary permissions.

It emerged early on in phase one that Barberton was a suitable area for me to carry out my research, and the institutional gatekeepers, particularly the CEOs and Senior Managers of Barberton General Hospital and Barberton Tuberculosis Hospital, were well disposed towards the research proposal. Once this had been ascertained I started making frequent trips to the town of Nelspruit forty kilometres away to begin what would become a long and drawn-out process of obtaining official government approval for the study, without which neither Barberton General nor Barberton TB hospital's executives would allow me to commence the research.

I utilised this period as an opportunity to immerse myself in Barberton and learn more about the town, some of its history and layout, and the various healing avenues available to town residents.

As this was only a first foray into the field, only minimal data was collected. This largely revolved around establishing how I might integrate myself into the facility, and how I might go about carrying out the research. Some of these early observations, and informal discussion with hospital gatekeepers did help in shaping the initial respondent interview schedule.

Particular themes that emerged from this preliminary stage included observations of a complex power dynamics within the Tuberculosis hospital, where patients are held, usually for a minimum of three to six months, and the complexity of the delivering biomedical treatment within this facility.

A second nascent theme that emerged was the consideration that nurses actively manage cultural collision, and the complexity of being a 'biomedical' professional who has to navigate and negotiate the dynamics of Western and African schools of thought. Note, these were only two nascent ideas amongst many, though in subsequent phases, when I began the formal process of data collection, they would emerge as two of the more significant lines of inquiry in my thesis.

### **3.5.2 *Fieldwork phase two***

I received the necessary academic ethical approval through the Universities of Edinburgh and the Witwatersrand at the beginning of fieldwork phase 2. However, I had to wait a further five weeks for official government health department approval before I could commence my study within the state hospitals.

I spent this interim period developing networks and introducing myself to various managers and stakeholders in Barberton General and Barberton Tuberculosis Hospital. I also spent the time further developing my understanding of medical pluralism in Barberton, and engaging more in local events. I was permitted to spend time talking to hospital gatekeepers and managers in an informal capacity, however, I was not yet permitted to talk to junior staff and engage in any formal discussions about the work.

Once government approval had been obtained, I spent the remainder of fieldwork phase two predominantly interviewing nurses and doctors in Barberton General Hospital. This proved to be a challenging undertaking. I began using an approach of informal (informant) interviews, so that I could introduce myself into the hospital in a manner that was less formal. I utilised this approach to help me understand how I might better shape the preliminary interview schedule I had developed.

It was evident that some of the questions on the interview schedule, had to be phrased differently to what I had initially expected. For example, a significant stumbling block was the use of the terms 'traditional healers' or 'traditional medicine', as these 'English' terms meant different things to different people.

A significant addition to my interview schedule, was then an informal opening discussion of what the terms 'traditional healing' 'traditional medicine' and indeed 'biomedicine' meant to respondents.

These preliminary interviews were instrumental in helping me to shape the subsequent interview schedule, and, following primary analysis of the emergent data from fieldwork phase two, the nascent lines of inquiry relating to the positioning of nurses as brokers of culture, and an exploration of the TB hospital as a site of overt biomedical power, solidified. It should be reiterated that most of the work in phase two was carried out in Barberton General Hospital. Furthermore, much of the informal, and formal interviews conducted in this phase resulted in

the creation of the typology – the foundation for section 4.4 of this thesis entitled ‘Hospital encounters with African Traditional Medicine’.

### ***3.5.3 Fieldwork phase three***

My time in Barberton during phase three was divided more evenly between the general and the tuberculosis hospitals, and was used to mainly build upon themes that had emerged in the previous phases. There were number of emphases in this particular phase including:

The exploration of nurses as broker of culture. In this respect I spent significantly more time exploring how nurses felt about being at the ‘nexus’ of cultural paradigms. In the analysis of the previous phase data, it had emerged that nurses positioning between patients and their expectations of treatment on one side, and the expectations of doctors, the majority of whom actively shunned any notion of non-biomedical healing on the other side, was a complicated position to be in.

The second emphasis in this phase was continuing with the exploration of TB patient narrative accounts of their illness and their journeys through a plural landscape. I also undertook a more nuanced exploration of the TB hospital as a site of overt biomedical power.

It should also be noted that while I remained in the field for the original allotted time, this research was largely curtailed three weeks before its planned end due to a bicycle accident sustained while travelling to an interview that was to be held at Barberton General Hospital.

#### ***3.5.4 Fieldwork phase four***

Phase four was a brief foray into Barberton in March and April of 2012, and was meant to try and make up for some of the research time lost due to my unfortunate accident. In this phase, I limited my meetings and interviews to staff and patients in Barberton Tuberculosis Hospital in order to discuss recent structural changes in light of the facility's upgrade from a primary TB treatment hospital to a multi-drug resistant treatment facility.

### ***3.6 Analytical approach***

Maguire and Delahunt (2010) state that thematic analysis is a method, rather than a methodology, meaning it is not associated with any particular epistemological or theoretical perspective, making it particularly suitable to this thesis in which multiple qualitative methods have been applied. I will however add that while I often see thematic analysis described as a step-by-step process that includes (i) familiarising oneself with the data set (ii) coding (iii) searching for themes, and (iv) reviewing themes (v) defining themes (vi) writing up (Braun and Clarke, 2006), this might imply that analysis begins once a data set has been produced. While not a strict ethnography, this work nonetheless is inspired by ethnographic technique in which the analytical process commenced not once a data set had been compiled, but at the start of the project, as Hammersley and Atkinson suggest, beginning with a pre-fieldwork phase in which formal analytic notes and memos are written up, alongside informal hunches, ideas and emergent concepts.

A good deal of textual data was generated from audio recording of respondent and narrative interviews, and the memos and field-notes generated. To help manage the textual data, and to assist in the organization thereof, I utilised a software tool called Text Analysis Mark-up Syntax (TAMS) Analyzer (Warters, 2005; Weinstein, 2006). An open source qualitative data management tool developed by Weinstein (2006) in which textual data can be digitally coded and managed.

I used a two-level coding process in which first level codes were applied to textual data – labelling groups of words and concepts, followed by second level coding, or pattern coding, in which initial codes were clustered into defined themes (Bowling, 2005).

The process identifying themes comes from “careful reading and re-reading of the data” (Rice & Ezzy, 1999, p. 258). The coding process while reading through the data involved recognising an observation or remark and, prior to interpretation, encoding it to ‘capture’ the qualitative depth and richness of the phenomenon (Boyatzis, 1998). A theme in this regard is described as “*a pattern in the information that at minimum describes and organises the possible observations and at maximum interprets aspects of the phenomenon*” (Boyatzis, 1998, p161). So, for example, whilst several different codes were generated on the ways nurses and doctors talk about how they encountered African traditional medicine within the hospital space, these rich observation were also grouped into two related themes, one on detailed typology – i.e. the different ways African traditional medicine is encountered, and a related theme on attitudes and views with respect to these encounters.

Coding was an iterative process that took place throughout the study. The identification of codes was undertaken iteratively, and early codes rigorously reviewed with respect to later emergent codes (and *visa versa*) to ensure that they I was reliably covering the entirety of possible perspectives.

The coding process, and the identification of subsequent themes was a complex and ever evolving iterative process with multiple stages. This includes, (1) the creation of a coding framework using TAMS analyser, followed by (2) the iterative testing of the reliability of these codes across the emerging data set. (3) Codes were then grouped into related themes, and subsequent related sub-themes. In this phase, it was possible to identify issues of consensus and conflict in relation to the phenomena discussed.

The complexity of the analytical process for the project was significant, as there was a clear progression of themes throughout the project, and the constant emergence of new avenues of inquiry which, as can be appreciated, resulted in a burgeoning of the coding framework, and resulting themes.

While the above gives an overarching impression of the process of thematic coding in this thesis, I do need to highlight that for narrative interviews with tuberculosis patients, in addition to a general thematic approach, I also augmented this by applying a narrative analytical framework where I draw from Labov’s clause structures, to explore not only the content and conveyance of the narratives, but also how individual narrative arcs can be related to Arthur Frank’s *narrative-types*. In effect, while I concern myself with both the content of narrative accounts regarding the plural medical landscape and patients’ evaluative experiences thereof, I also explore the moral calculus surrounding narrative positioning, and

the manner in which patients cast themselves as protagonists within their individual narrative accounts.

### ***3.7 Ethical Review and Project Approval***

Level two ethical review for this project was obtained from the ethics committee within the School of Community and Population Health Sciences at the University of Edinburgh, as well as the ethics committee at the Department of Anthropology at the University of the Witwatersrand, Johannesburg (see appendix 3 & 4). These, along with the research proposal, were presented to the Mpumalanga Department of Health for review, the subsequent letter of approval (see appendix 5) allowing me to begin interviews and discussions within Barberton's state run biomedical facilities.

The above paragraph précis several months of work, in which numerous refinements to the project proposal, and numerous meetings with institutional executives and government officials were undertaken. In reality, these months span a complex process of negotiation and relationship building, a period of backwards and forwards moves between institutional and government executives, with a great deal of side-ways tacking along the way. Moreover, even after the initial study protocols were deemed to be ethically robust and appropriate to the study aims, the reality of negotiating with institutional gatekeepers meant that a government letter of permission is not a skeleton-key that would guarantee me access at all levels. Instead the letter of permission from the Mpumalanga Department of Health was usually good enough to gain me access to gatekeepers lower down institutional hierarchies, where I would have to once again negotiate entry to staff at these levels.

What I mean by this is that institutional access was not attained by default once approval of the research has been granted by the government and by the most senior persons within an institution, but rather access negotiation is a continuous process undertaken throughout the study, and with a variety of institutional gatekeepers from senior managers and department heads at the top of the hierarchy, to staff nearer the bottom.

### 3.8 *Reflections*

While reflections are interspersed throughout the thesis, certain aspects of the project are more fittingly addressed within this chapter. Many of these reflections are broad and deal with working across methodological, cultural, and disciplinary boundaries, while others revolve around the challenges of engaging in a research topic that has sensitive political, social, economic and cultural dimensions. I also include in this section detailed accounts of experiences that would subsequently come to assist me in my attempts at understanding the nuance of Swazi culture, and how this in turn relates to my attempts at achieving a level of social access within Barberton TB and Barberton General Hospitals.

#### 3.8.1 *Reflections on Acclimatisation & Access Negotiation*

As a born and bred South African, who has already undertaken research dealing with aspects of South African culture, development, livelihoods, and health, I was able to benefit from my previous research experience when locating myself in Barberton. This is not to imply that I entered Barberton shut-off to new experiences and perspectives, indeed throughout the project my preconceptions, and indeed misconceptions, about South African society and culture evolved considerably.

Nonetheless, I entered the field sharing a common understanding with local residents of what it means to be South African. I did not require an explanation of why residential areas largely remain separated into White, Indian, Coloured and Black despite the two decades since apartheid's dissolution. Neither did I need a translation of most South African colloquialisms that enliven conversation and interaction.

Cassell (1988) describes two-stages of field access. *Getting in*, which is the process of negotiating field-site and institutional access, and *getting on*, described as attaining social access. Of the two, the former comes across as the more formal and officious as it requires meetings with institutional executives and government officials as well as a knowledge of what institutional structures and codes need navigating. This said, the boundaries between *getting in* and *getting on* were often blurred. Formal meetings would often venture into informal discussions, and similarly, discussions with people I had come to know informally outside the hospital, sometimes led to more formal discussions within.



There were instances in which the actual process of getting in, where I was compelled to adopt a top-down approach by first negotiating with institutional executives, would ultimately come to hinder my attempts at achieving social access with people who were wary of my apparent affiliation with senior hospital management.

In this discussion of acclimatization and access negotiation, it is important to distinguish between acclimatization to the two hospitals as research sites, and to Barberton and its immediate surroundings areas.

Although this project focuses predominantly on two state-run biomedical institutions, events and experiences occurring out with institutional boundaries were to have a profound influence on how I engaged with participants within. Events external to the two hospitals ultimately came to influence my understanding of the social and cultural dimensions of healing, and health decision making in the locale. These external events also influenced the process of data collection, my interaction with participants, and how the project unfolded.

While it would be impractical to précis all my experiences and interactions, I would like to highlight two in particular. The first being the *intfwasa*, a sangoma graduation ceremony, and the second being the annual *Ummemo*, a Swazi tribute festival held on the tribal authority property of the local Chief Kenneth Dlamini. I highlight these two events in particular, as my firsthand experiences and observations from these events, would later influence my access and interactions in Barberton's hospitals.

### ***Intfwasa ceremony***

The *intfwasa* ceremony, is a sangoma initiation ceremony that I was fortunate enough to have received an invitation to courtesy of Gogo Phakati, a 'White' sangoma, who at the time was graduating two of her students. The ceremony was held on a rural homestead lying between the towns of Dullstroom and Lydenburg, approximately 135 kilometres north of Barberton over pitted and potholed highways.

When I arrived at the homestead in the company of Professor Thornton's former research assistant, as well as a group of traveling museum<sup>55</sup> performers, Gogo Phakati, and her daughter Gogo R (pronounced Rha), along with a third sangoma, were kneeling at the threshold. They had begun gesticulating and crying out in siSwati, grunting and breathing

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<sup>55</sup> The travelling museum was a group of young performers working with Professor Thornton. They were drawn from the local Barberton community, and would perform plays revolving around Swazi culture, those in particular which I was able to see myself, dealt with aspects of traditional healing.

heavily as they knelt at the homestead threshold. According to Zakhile, Professor Thornton's former research assistant who was assisting me in these early stages, the tangoma were channelling the voices of ancestors as they addressed the assembled. Zakhile went on to explain: *"When you see them dance inside, they will make noises and dance like the floor is hot, because to the spirits inside them, the ground feels hot"*

When we eventually entered the homestead to the resonant throbbing of drums, it did indeed appear as if the ground was hot to the three sangomas as they danced and hopped around from foot to foot with their lips curled up in expressions of pain. *"The drums have to be beaten right otherwise it doesn't work."* explained Zakhile. Zakhile said this to me as we both noticed a trainee sangoma grabbing a stick out of a young girl's hands with a rebuke and a scowl, and took over the drumming with fervour. If the drumming was not initially up to par, it had not deterred the three dancing tangoma. They danced around energetically, a vertical skip and hop from foot to foot, thrusting sticks into the air, sometimes whooping, sometimes screaming, sometimes expelling bellyfuls of air with a deep moan and grunt, and drawing it in again through clenched teeth with a hiss as if the hard-pack floor really was a bed of hot coals. Sometimes they would kneel in front of a person, and break out into punctuated Swazi while struggling to draw in deep bellyfuls of air. Rivulets of sweat were pouring off the three of them, carving channels on dust-coated skin. *"That's the ancestors talking to the person they are kneeling in front of. The person has to speak back to ancestors"* said Zakhile.

At some point the initiates disappeared around a corner where, I had been told, a goat was being slaughtered. I was not certain if the initiates themselves were doing the slaughtering, although if this ritual resembled sangoma initiation rituals from other parts of South Africa, this would be the case (Wreford, 2008). *"Someone will hide the goat's gall bladder..."* Explained Zakhile *"...and one of the tests is for the ancestors to guide the initiate to where it is hidden."* Though I did not stay for the entire ceremony, I did eventually get to see the two initiates, two young men, dancing, jumping and skipping rhythmically like their gobela Gogo Phakati a few hours before. They too were sweating, grunting, drawing fluttering bellyfuls of air, and seemingly detached from the crowd around them.

The initiates knelt down in front of Gogo Phakati's gobela (trainer / teacher), an older man who was sitting apart and observing the proceeding with a critical eye. This *senior* sangoma would later also get up to dance, and it was clear that Zakhile was looking forward to this. *"He has a long snake skin which he got in the water."* suggested Zakhile rather cryptically.

The significance of both snakes and water to sangomas was known to me, and, in my few weeks in Barberton, I had come to learn that it was widely accepted that the most powerful sangomas are those that receive instruction from spirits under water. When I explored this further in my first weeks in Barberton, I admit to being somewhat perplexed. *“They go and live under the water for a few weeks, maybe months.”* Zakhile had said when we first broached the subject. I had grappled with the physics of this statement, sometimes probing whether people interpreted this as a literal and magical sub-aquatic experience, or whether this was interpreted as something metaphorical – i.e. seclusion and meditation or spiritual immersion. *“I don’t know how they breathe, but they do actually go in the water and live there...”* had been Zakhile’s reply, as had been the reply of many.

Photographs 1: Start of iNtfwasa graduation ceremony



Photographs 2: Tangoma dancing during iNtfwasa graduation ceremony



Source: Author's own photograph



Photographs 3: 'Channelling' ancestors at the iNtfwasa ceremony



Source: Author's own photograph

When the senior sangoma started dancing at the *intfwasa*, his snake skin was indeed on full display. Attached to his head, the cured skin trailed his movements across the room as he danced. Unlike his students, he did not jump energetically and erratically around the courtyard, instead his movements were deliberate, sedate, and fluid. He was, after all, very much older than the youth who had recently been raising dust. We left soon after his dance, and he came up to me to say his farewells. I asked him about his snake, and where he got it. “*I used to work in Mozambique on a farm, and I killed it with my spade when it was trying to eat my dog.*”

There was much about the *intfwasa* that was entirely alien to me. Though I had interviewed *tangoma* before, I had never witnessed any major ceremony, and to say that I fully understood the events that took place, and the meaning of behaviours and actions, would be misleading.

My point in recounting this event is that despite it occurring far beyond the institutional boundaries of Barberton’s general and tuberculosis hospitals, there were many occasions when speaking to informants and interviewees therein, where I refer to these events to try and reach for some personal understanding. Many informants had very good, usually first-hand, knowledge of the events, actions, and ceremonies of the *intfwasa*. For some study participants, my revelation that I myself had attended an *intfwasa* ceremony was in many instances quite valuable in building rapport. I was not merely a White man descending on the hospital to discuss contested boundaries between African and Western medical philosophies, but was seen as trying to reach for an understanding of Swazi culture in the process. And this in itself was appreciated by many interviewees, which helped me establish better rapport and attain social access.

### ***Ummemo celebration***

As one of the few curious White faces present at the Ummemo festival I attracted some attention. It was partly curiosity that drew Sambulo to me, greeting me with “*Hey, it’s good to see a White here.*”

Phase two had just begun and I was accompanying Professor Thornton and his team of travelling museum performers to the annual Ummemo – a Swazi celebration held on the tribal trust property of Chief Kenneth Dlamini. The direct translation of *ummemo* is that of a working party summoned by a king or chief (Rycroft, 1981). Traditionally a gathering for the purposes of rendering service and renewing fealty, it is also a significant community

event that celebrates and reasserts local Swazi culture. The event was staged by Chief Kenneth Nkosi Dlamini on his homestead – formerly a White-owned farm located approximately four to five kilometres to the West of Barberton town. The event included ceremonial dancing of local Induna's (headmen) and elders who were paying respect and renewing fealty to the chief; plays staged by performers in Professor Thornton's travelling museum depicting aspects of Swazi culture – specifically plays of the interaction between patients and sangomas; vigorous intimidating displays of Swazi dancing and drumming staged by foot stomping, weapon wielding *sibhaca* dancers (see picture x); as well as the annual reed (*umhlanga*) dance performed by unmarried and childless, ostensibly virginal, young women. The name of the dance referring to the harvested reeds that would traditionally go to repairing the chief's wife's windbreak and enclosures around the homestead.

I was standing in one of three newly constructed kraals observing three cows being slaughtered and quartered. One carcass was being skinned, cleaned, and cut up by a team of, quite literally, old-hands, the other two carcasses by a team each, one comprising young men, the other young women. I would estimate that none of the young men and women were past their mid-twenties, with a few looking like they had yet to emerge from their teens.

Photograph 4: (above): Indunas paying fealty to chief Dlamini

Photograph 5: (below): Sibaca dancers and drummers



Source: Author's own photograph



It was in this kraal that Sambulo had spied me, and approached me with a smile. I was engrossed in the bustle of bloody activity, and while trying to ignore the somewhat rank and pungent odour of blood and faeces pooling and littering the ground at my feet, Sambulo proceeded to probe in quite a direct manner, asking if I as a White thought it strange to be observing the slaughter. *"Whites just don't do this sort of thing... but us Blacks are used to this, its normal..."* After I admitted that this was indeed the first time I had seen a mammal being slaughtered and dismembered, Sambulo proceeded to probe me for my views and opinions on my grim observations.

Whilst most people were in traditional Swazi attire, Sambulo, like myself, was dressed in jeans and a smart button-down shirt. Young and smiling, with a Nokia phone clipped to his leather belt, he walked around gingerly in smart shoes carefully avoiding the scattered mess of blood and excrement. I felt that he was trying to tease some expression of disgust or distaste from a curious White man looking very out of place observing the bloody scene, however he was good-natured, and friendly.

Having explained I had never before witnessed the dismemberment of any animal, he, along with Professor Thornton who I discovered was somewhat of an expert in hunting, kindly began pointing out a number of things about the manner in which the three teams were going about the gory business, in particular criticising the inept and messy manner in which the two inexperienced youth teams were going about their kill.

It was evident that both youth teams were struggling with their task; flailing and sweating as they darted around the cows, occasionally trying to wipe blood off their brows as they went along, though in truth only succeeding in smearing it around even more. The older men, however, were efficient, controlled, and quite clearly working in synergy, some supporting the carcass and pulling limbs and muscle taut where necessary, while others darted around them, slicing here, cutting there. Where the sand and grass around the youths was splattered crimson, and where dark faeces and stomach contents had corrupted pink muscle and white sinew, the area around the older men was neat and tidy, with blood and fluids neatly channelled and faeces removed well away from the meat itself. One of the older men neatly sliced through a section of the cows voluminous guts, and slipping his hands inside, scooped the green half-digested cud into a large metal basin. *"They will cook and eat that."* said Sambulo. I was not sure if he was being serious, or trying to elicit an involuntary grimace on my part.

While this is only a snapshot of my time at the ummemo, and while my observation of a traditional slaughter of cattle may appear a far removed event from the work that was to follow within the clinical corridors of Barberton's general and tuberculosis hospitals, in truth the event assisted me a great deal in negotiating the social world of the two biomedical institutions whose staff are predominantly drawn from the local Swazi community. This started with Sambulo because as it turned out he was, serendipitously, a nurse based in Barberton general hospital, and a person who became a significant informant. Someone who would later help to validate my presence and subsequent discussions within some hospital circles. In some ways my acquaintance with Sambulo, who was not a senior staff member within the hospital, mitigated the perception of me by some as a White researcher aligned to the institution's management.

Furthermore, as a minority White face (one of five as of my count) in the ummemo crowd, my presence was remembered and later recalled by nurse participants who had also been present at the celebration providing a natural icebreaker and hence easing communication. Attaining social access within the biomedical institutions pivoted not only on developing some knowledge of local Swazi culture, albeit a limited one, but also in how I as an educated relatively wealthy White was perceived by respondents.

The *Ummemo* and the *intfwasa* illustrates the overlap of my general acclimatization to Barberton town and its surrounds with institutional acclimatization and access. During these early interactions, I did attain a much deeper appreciation of the need to allow participants and respondents to freely 'feel out' my own perceptions. Both the *ummemo* and the *intfwasa* ceremony helped significantly in opening up myself to a very different perspective, while at the same time providing purchase for interviewee and respondents to explore me and the purpose of my presence.

### 3.8.2 *Getting in: Negotiating Institutional Access*

Whilst awaiting for officials at the Mpumalanga department of Health to review the study, I began meeting with a number of relevant stakeholders – hospital executive officers, senior nurses, senior doctors, and board members of both institutions. These meetings gave senior staff the opportunity to discuss my proposed research face-to-face, and it also gave me an opportunity to get a better appreciation for the feasibility and relevance of my project aims to the research area.

During this early phase of negotiating institutional access, there was also a frequent misapprehension on the part of many senior biomedical professionals that my project aims were to explore the dangerous consequences of African traditional medicine, and it took several attempts in some cases to emphasise that this was not my intention. The process of negotiating institutional access was also then a process of managing expectations of institutional gatekeepers, and in many respects this early negotiation process was itself quite illustrative of some of the less than positive views and perspectives of African traditional medicine held by many biomedical professionals.

Alongside holding informal meetings with staff in Barberton's hospitals, my weeks would be punctuated by wandering the labyrinthine corridors of the Mpumalanga Provincial Government buildings in nearby Nelspruit searching for the official(s) that could, and would, authorise my research. Of all the iterative steps in negotiating institutional access, this was by far the most challenging. While it was heartening that senior management staff in Barberton General and Barberton Tuberculosis Hospitals were well disposed to the project, actually making contact with specific people within the Mpumalanga department of health who were tasked with reviewing the research proposal was quite the opposite.

The government complex in Nelspruit is a newly constructed labyrinth. Week after week I would find myself being passed along from one office to the next, where mornings and afternoons would be whiled away waiting for one official or another to keep an appointment.

Frustratingly, this process had not begun in phase two, but rather I had put the ball in motion for obtaining government approval during phase one. The frustrating sojourn through the government offices came to an end one day when one of my visits happened to coincide with the lunch break of the individual who was overseeing my research application. Impatient with the polite and measured approach I had been adopting by trying to book meetings through various secretaries, meetings that would usually be cancelled with no notice, I

decided to bypass the usual gauntlet of gatekeeper-secretaries who at that moment were out to lunch. In effect, I politely gate-crashed the civil servants lunch break at his desk.

What followed was half an hour of what a one-time mentor in development studies termed *schmoozing*. After brief introductions, my discussion with this official did not revolve around the research, but rather our respective experiences in undertaking post graduate public health degrees, his in Sweden, mine in Scotland. The talk eventually segued into my own proposed study, to which he asked when I would be beginning. I replied that I was waiting for his permission on a letterhead. Five minutes later I received a letter of authority that allowed me to commence the institutional arm of my research.

To this day I cannot help but interpret this letter not so much as a mark of bureaucratic authorisation and legitimisation of my research, but rather I see it as a symbolic article of achievement for having successfully navigated a creaking government bureaucracy. I have tried to distil this experience in the above paragraphs, however, the above account has been ruthlessly pruned of the twists and turns in the story, debrided of the frustrating phone calls, obfuscating secretaries, dead-end emails, and infuriatingly cancelled meetings.

I should also mention that the official letter of research authorisation also held symbolic meaning for senior and junior staff at Barberton General and Barberton Tuberculosis Hospitals. It was a letter conferring legitimacy of my presence and actions, but it was also a letter that hindered my research, often leaving me in a catch-22. This letter might well have been the overarching symbol of legitimacy, however, it also was a symbol of my affiliation with senior management and the wider government health department. I was not just a researcher, but a government sanctioned researcher complete with letters of authority who came by way of senior staff. To develop social access, I needed to be seen as bureaucratically and institutionally legitimate, but in doing so, this sometimes hindered my efforts at achieving social access amongst staff who were dissatisfied with senior hospital management. This was because phase two of the project coincided with a public servant strike in the initial weeks, a strike which was a significant, and controversial talking point amongst staff.

Battle lines between junior and management staff within the hospitals had been drawn, and there was some dissatisfaction directed towards senior staff. That the letters of authority loosely affiliated me with management, and the wider provincial department of health, I feel, did lead to some suspicion of my presence amongst some junior staff about my motives. This was evidenced by the questioning from some junior staff enquiring about the *real* purpose of

my presence in the hospital, insinuating that my project was in essence a front for something else.

### 3.8.3 *Getting on: Achieving Social Access*

As I went about introducing this study to Barberton General Hospital's senior managers and gatekeepers in the early stages of the project, many communicated their concerns about the challenges I would encounter when recruiting study participants. Doctors, they mused, would most likely be keen participants, however, scheduling a block of interview-time would be challenging due to constraints of heavy clinical workloads. This was, in turn, exacerbated by an acute shortage of doctors within the hospital.

The converse appeared to be the consensus concern for nurse recruitment. Securing interview time was not seen as much of a barrier, instead, the prevailing view was that many nurses might be reluctant to engage in discussions in which African traditional medicine was a primary topic. As one nursing manager elaborated:

*All of them, or maybe eighty or ninety percent [of nurses], take traditional medicines themselves. That is why I think they will probably not want to talk.*

*Nurse Dlamini*

As the project unfolded, I felt the weight of these concerns materialise in the heavy reluctance, and air of weariness, exuded by many nurses, to my interview overtures. The topic of African traditional medicine, combined with the prevailing impression that I was, in some way, an official connected to the Mpumalanga department of health, proved to be a powerful deterrent to participation. However, despite these very real challenges, I did succeed in drawing together nurses and doctors from across the staffing-body.

There was no single strategy I would use to help further embed myself into the social bodies of either institution, and indeed, to some extent I would be arrogant to claim that I did in fact achieve a level of social acceptance amongst the many staff. However, certain events, such as the *ummemo* and the *intfwasa* ceremony, were helpful in many discussions as a way building rapport whilst undertaking fieldwork.

I soon came to realise that while I could interact with people, make friends and acquaintances, and embed myself into the research area in a manner that would approximate a level of social acceptance, this, I feel, was only partial, and feel I cannot claim that I was

fully accepted in either facility. This, however, did not mean that I did not try to socially embed myself, as described in the following account.

It was during week four of the second phase, and I was waiting in the newly built central administration offices for a scheduled meeting with one of Barberton general hospital's senior managers. Two previous scheduled meetings had been cancelled, and I was now returning to try for a third, which as it turned out, also did not go ahead. During my wait, I made acquaintance with Patricia, the hospital's primary administrator. As we were talking, Patricia started manoeuvring large and heavy boxes around the room. The boxes contained dusty books and files which Patricia began removing and organising into a tall and warped gun-metal grey cabinet.

I arrived at the hospital just in time to witness the dusty relocation of the management and administration offices, which sat on the periphery of the hospital site, to a newly built wing in the centre of the sprawling complex. Patricia had been tasked with the job of sorting out a stack of large boxes, and since I was only waiting for a meeting, which I suspected would soon be cancelled, I offered to lend a helping hand.

Together we sorted through, and catalogued dozens of text books, files, notes, and folders of official hospital rules and regulations into the steel cabinet. As a bibliophile, I admit I took some satisfaction in the act of filing and organising, and while doing so, I was making a mental note of the small library of books available to staff members and doctors. It was, after all, a teaching hospital. Interestingly, there were even a fair number of old text-books on the social sciences in medicine, though compared to the dog-eared pages of the frequently referenced paediatric and surgical texts, these pages of the social science books, though yellowing, were nonetheless crisp, clean, and neat, a testament to their relative infrequent use.

After an hour, I resigned myself to the fact that my meeting was once again cancelled, and continued filing and stacking books with Patricia for the next several hours. During this time, I was able to introduce myself and my proposed research to her, as well as a number of her colleagues and friends that passed through. I was also in a position to be able to observe the comings and goings of doctors and nurses to the office, and just as importantly, they were able to observe me. The office was the hospital's administrative nerve centre, and over the hours I spent helping Patricia, I was able to learn a great deal about the hospital's structure, the departments, and key staff members therein.

Though I did not know it at the time, Patricia would become a significant contact in the hospital, less someone who contributed to the contextual aims of the study, and more someone who was vital in the process of manoeuvring and navigating through the institution. As an administrator, Patricia had her finger on the pulse of the institution, able to identify doctors, nurses, schedules, and regulations instantly. Very well liked in the hospital, Patricia would help significantly with the process of attaining social access in many areas of the facility. Along with Sambulo who I met at the *ummemo*, they represent two nodes in the general hospital's network that helped me navigate the social and institutional landscape. Sambulo provided a gateway into non-managerial terrain, while Patricia served as a link across all hospital divisions.

Despite the assistance of both Patricia and Sambulo, attaining social access was fraught with challenges on many levels. Some of the most significant challenges in this respect I put down to several factors: the nature of institutional hierarchies; the topic of my thesis which could sometimes be contentious; the perception of myself in the eyes of respondents as someone allied to senior management; and of course the different methodological approaches used in my research also made achieving a level of social access quite difficult. Furthermore, there was very little I could do to blend-in, and immerse myself in either facility. In addition, there was a clear lack of continuity in my research because of the number of phases undertaken. That is, successive exits and entries over various phases proved to be a challenge, and each time I re-entered the field I found myself having to re-explain my position, my role, and my aims as a researcher to various interviewees. In hindsight, I do think it might have been better to have entered the field for a continuous uninterrupted period.

The approach I used in my research was overt. I did not construct a deceptive rationale to explain my presence when introducing myself to staff and potential participants, however, a rationale still needed to be constructed. While I was entirely honest about my presence, this did not by any means mean the explanation of my presence was accepted at face value by all present. I have already mentioned in this chapter that I encountered instances in which some participants found my proximity to hospital management suspicious. *Who do you work for? Why traditional medicine? Are you working for the government?* - were questions that while not common, were certainly not absent. The last in particular was asked of me more than once given that my presence in the hospital coincided with significant civil service strikes and widespread discontent with the government, and indeed hospital management.

Questions like the above were not usually asked in formal interview situations, but rather in informal settings and during informal introductions, and they indicate a certain level of suspicion of my presence amongst some. And there were instances in which moving through the facility to recruit participants to the study, served to promote suspicion, and in some instances a negative attitude towards myself. Once such a circumstance arose directly because of my proximity to a member of the hospital management.

I had mentioned in passing to Matron Dlamini that I was having trouble recruiting people to participate in the semi-structured interviews. Doctors were impossible to get hold of, and many nurses expressed no interest in having a discussion, even after I spent a great deal of time within the facility answering questions and informally discussing the project. To my surprise, Matron Dlamini contacted me a few hours later putting me in touch with a nursing lecturer who was happy to be interviewed. I was grateful, but also a little wary of having management staff personally involve themselves in recruiting participants for the study. This particular manager had a certain level of enthusiasm for the project, and respect for the subject of medical pluralism that many other clearly did not share. The 'snowballed' nursing lecturer she directed me onto was certainly happy to participate in an interview. Following our interview she sparked up a discussion on the difficulties I was having recruiting people, similar to the one I had had with Matron Dlamini. Matron Dlamini had clearly mentioned my challenges to her.

The nurse lecturer offered to take me around to one of the wards and introduce me to some of the junior staff so as to help me break the ice so to speak. We entered the ward where I was introduced to two junior staff who were manning the nursing station. Unbeknownst to the nursing lecturer, I had already met these two nurses. They knew who I was, and what I was doing in the hospital, and both had already declined to be interviewed only a few days prior.

While I was certainly grateful for the above referral from the nurse-lecturer, it presented a particular conundrum. As the nurse-lecturer introduced me to the junior staff, they would not make any eye contact with me. I felt somewhat embarrassed about the situation as it plainly looked like I had gone above their heads following their choice not to be interviewed. It appeared as if I had spoken to a manager because they had declined an interview, and it was evident that the presence of the nursing lecturer, and her personal introduction of me, was interpreted as an 'order' for them to assist me in my research.



The first individual consented and we began the interview rather awkwardly. I suggested that she did not have to do the interview, and apologised for that the nursing lecturer had asked her to participate, with an explanation that the lecturer was unaware that she had already declined. However, the reluctant interviewee persisted with our discussion.

When it was completed roughly forty-five minutes later, she disclosed the reasons for her initial apprehension and refusal. She explained that she had no concerns about discussing African traditional medicine *per se*, however, she had assumed that she would not be able to answer any of the questions, and thought she would be of little help. I got the impression that she was embarrassed, and afraid of appearing ignorant. She would later emerge as a friendly and welcoming face, and declared that she found our discussion both informative and interesting, so much so that she even persuaded a friend of hers to participate. She also emerged as a useful person to approach in times when I felt like I needed to clarify a point relating to African traditional medicine, such as the names of so-called 'Bantu' illnesses.

The second nurse who felt compelled by her manager to be interviewed against her wishes, was clearly unhappy. Not wanting to engender negative feelings or attitudes to myself, or jeopardise any goodwill I was trying to establish amongst the staff, I left her my card and a copy of the project summary, with the impression that she could contact me if she ever wanted to participate.

#### **3.8.4    *Undertaking research on an emotionally & culturally sensitive topic***

There were significant challenges to carrying out research on a topic as emotionally charged as this in Barberton's hospitals, and throughout the research I would confront numerous, and quite distressing accounts of the 'dangers' of Africa traditional medicine, and how these emerged in the hospital space.

A prominent example of one such distressing incident revolved around the sad case of a child whose feet had been amputated because her grandmother had taken her to a 'traditional healer' where 'treatment' had involved suspending the unwitting child over a fire. The resulting gangrenous, suppurating burns, and the resulting double amputation, had irrevocably altered the child's life-trajectory. To say that staff in the hospital were incensed by these events would be an understatement.

In the early weeks of phase two interviews and discussions, it was very difficult to ignore that I too was resonating with the prevailing atmosphere of umbrage projected by many staff

as a result of this incident, and many would point to this as evidence of the dangers of ‘primitive beliefs’, and the horrors traditional healers visit upon children in particular.

Trying to sort through the morass of this, and similar, incidents was challenging, and indeed often paralysing. In exploring African traditional medicine within a biomedical space I had to confront the complex power-dynamic between systems, and accounts of injury and treatment that would lead me into a complex moral landscape where ethics and basic human rights appeared to be superordinated by claims of cultural authority and primacy. And in a public institution of a new post-apartheid South Africa, it appeared to be important that one not undermine cultural authority, lest one be branded neo-colonial. Indeed, these accounts of the dangers of African traditional medicine were largely conveyed in whispers and in private discussions.

I soon came to realise that many negative accounts about African traditional medicine resulted in me viewing my fieldwork through a somewhat jaundiced, and perhaps a biased, lens. And these served only to reinforce my predisposition towards a Western biomedical paradigm, making it a challenge to approach my work with fair and critical oversight. Indeed, my early field note diaries are filled with alarming accounts of the results ‘African traditional medicine’, as dictated by doctors and nurses in the quiet corners of the facility.

After about a month in the facility I found myself in the hospital CEOs office. The matron, a former nurse, immediately sensed my distress, and enquired as to my wellbeing. I explained to her that the nurses and doctors who had agreed to participate in the study, which at that point were few, overwhelmingly cast African traditional medicine into a negative light. Whilst this in itself was not a problem, as all interactions need to be considered in terms of context and positioning, what was concerning was that I could not rid myself of the negative lens through which I was coming to interpret African traditional medicine and subsequently, how I was navigating respondent interviews.

The CEO, an extraordinarily busy, but also extraordinarily intuitive person, encouraged me to cast a more symmetrical gaze in my efforts, and surprisingly, told me to consider the mistakes that happen at the hands of physicians. Mistakes that I would not hear from the biomedical staff themselves. She then spent the next few minutes recounting the story of an incident in 2008, when a three year boy underwent a circumcision at the hands of a Barberton hospital intern. The young boy was sent home by the junior doctor, whereupon his mother discovered that, not only the foreskin, but also a significant portion of the glans of his penis had been amputated (Mashile, 2011a, 2011b). No police were called in, and no charge

of assault, or battery arose, though the intern, and her supervisor, received a reprimand. It appears, that only recently, five years after the event, is the case being taken to court by a constitutional rights lawyer (Oosthuizen, 2013).

The CEO had been instrumental in these early stages in helping me to ‘recalibrate’ my lens, whilst at the same time lending a sense of perspective and distance from my own emotional resonance, as well as my predisposition to a more scientific view on public health.

I continued with interviews, and with a bit more perspective, could see that in many respects, accounts of biomedical professional’s encounters with African traditional medicine, were conveyed by individuals who often feel unable to fully articulate their frustrations within the institutional hierarchy of the hospital for fear of upsetting the delicate balance of political and cultural sensitivity. In short, nobody wanted to formally rock the boat in one of South Africa’s model, post-apartheid, ‘rainbow-nation’ hospitals.

### **3.8.5 *My own epistemological leanings***

One of the more significant challenges of undertaking this thesis has been the need to navigate a cultural landscape, interacting with individuals who take very seriously matters of a spiritual and esoteric nature. In this respect, it is necessary to state from the outset that my own interpretation in relation to this thesis, is deeply informed by my own position of secular post-enlightenment materialism – that is, I confess it a challenge for me to take seriously the claims expressed by individuals which revolve around matters of the seeming supernatural.

This said, it is impossible to ignore that spiritual, and indeed physical, insecurity in Barberton, and in wider South Africa, is intimately intertwined with matters that those of a Western philosophical orientation would consider esoteric and occult. Ashforth (2005) discusses confronting the self -same challenges in his own research experiences in Soweto, where he describes the difficulties of trying to understand context and meaning when one is constantly dismissing the literal allusions made by respondents. How, for example, should I take seriously the constant reference to knowledge and skill revealed by ancestors in dreams and trances? Indeed, I find it very difficult not to be disparaging of people who claim this ‘revealed’ knowledge, particularly with regards to those who seek material gain – as my account of Zeblon Gwala in the opening pages of the forward chapter illustrates.

While I have been fortunate to witness *tangoma* ‘channelling’ spiritual and ancestral entities, where others hear the voices of spirits, and see the dancing of a ‘possessed’ healer, I interpret an elaborate act, a display that has been learned and refined through rigorous training. Where others claim and emphasise literal truth, I interpret these as elaborate metaphors. A prime example in this instance being the oft-repeated claim that the most powerful *tangoma*, are those that spend a significant amount of time receiving instruction under water where it is claimed they live a sub-aquatic existence for weeks or months at a time.

There were significant challenges in having placed myself in a position where I had to confront, in a neutral manner, the views and beliefs of respondents who would wax eloquent about the dangerous influence of bad spirits, troublesome neighbours casting the evil eye, evil witches, and malicious *tangoma*. And yet while I cannot bring myself to believe that such an objective ontological reality does exist when people evoke the occult, I came to appreciate how this is of fundamental importance to those who do believe it. And perhaps of such vital importance as to influence both physical and mental health outcomes.

Related to this challenge of trying to understand African traditional medicine, is that it does not exist in a moral vacuum. While the contested claims on the nature of reality made by traditional healers and their adherents make for an interesting ontological, and epistemological discussion, such contestation are, sadly, not restricted to mere discourse. Beliefs in African traditional medicine are, unfortunately, responsible for needless morbidity and mortality.

My own epistemological position also made it quite challenging to interact with some individuals. I could not ignore that I had placed myself in a position where I had to consider that I was being viewed as the White man engaging with exotic African ‘beliefs’, and that many respondents might well not appreciate being positioned as ‘exotic’ research subjects. Therein lies a significant problem in that despite trying very hard to come across as an impartial researcher, Black respondents often assumed, and were not incorrect in their assumptions, that my own preconceptions and views of African traditional medicine were informed by my Eurocentric enlightenment rationality. This must have certainly influenced how respondents interacted with me. Indeed, those individuals who claimed to shun the ontological and epistemological claims of African traditional medicine, saw in me an ally, and were arguably a little more vocal in staking out a position, whilst those claiming to adhere to traditional medicine, would venture opinions in a wary and non-committal manner, and would only outline positions fully after I had established that though I had my own

preconceptions, I was approaching the study as a respectful, and neutral researcher as possible.

Indeed, the need to appear to affect a neutral position within a public institution, seemed to be a significant point raised by a number of respondents themselves, as some who came to voice concerns and dissatisfaction with African traditional medicine, felt that the ‘institutional culture’ which appeared to promote a kind of wider cultural and moral relativism in an attempt to respect the vast diversity of beliefs held by South Africa’s population, was itself very damaging.

### **3.9     *Summation***

This particular chapter provided the shape and contours of the methodological and analytical lens used in this thesis, a review of what methods were applied, how the project evolved as a consequence, and a number of pertinent reflections. The chapter following this provides a background to the town of Barberton, my observations on therapeutic avenues in the town, and an overview of the two biomedical institutions in which the research was carried out.

## ***Chapter 4: A Background to Barberton and the Research Sites***

### ***4.1 Chapter overview***

This chapter provides an introduction to the study area and the research sites. Part 3.2 outlines the town of Barberton and its roots in South Africa's late 19<sup>th</sup> century gold rush. I discuss early health and sanitation, along with impressions of African traditional medicine by European settlers.

Part 3.3 presents my observations of present day Barberton drawn from my time in the field. In this section, I discuss the town's demographics, with an emphasis on racial demographics where, despite two decades since the dissolution of apartheid, residential areas remain largely divided by race. This section also includes a brief discussion of racial tensions, drawing from observations and issues raised by project participants.

Part 3.4 deals with matters of medical pluralism, wherein I introduce some of the various healing avenues available to local residents. 3.5 concludes this chapter with a comprehensive overview of the two biomedical facilities at the heart of this project - Barberton tuberculosis and Barberton general hospital

## 4.2 *A Background to Barberton*

The town of Barberton is situated in South Africa's eastern lying Mpumalanga province, and sits in an area of the Lowveld known as the De Kaap Valley basin. The northern border of Swaziland lies approximately forty kilometres distant, reached via a steep climb through the meandering passes of the Makhonjwa mountains, and the coastal Mozambican capital, Maputo, formerly Lourenço Marques, lies roughly one hundred and eighty kilometres to the east.

Figure 9: Location of Barberton, South Africa



Tucked away from major cities or transport routes, Barberton is not much in the way of a thoroughfare, leaving me with the impression of being stuck in a somewhat sleepy and isolated frontier town. An impression reinforced by the many local heritage sites celebrating Barberton's origins in South Africa's late nineteenth century gold rush. From the memoirs of D.M Wilson, the first appointed Gold Commissioner for the De Kaap Valley, we have a description of the town's birth.



*With the proving of the Barber's Reef, a new era may be said to have begun on the fields. I had communicated the facts of the find to the Government, who instructed me to take the necessary steps to declare the vicinity of the discovery a township. So in February 1884, in the presence of several diggers... I broke a bottle of gin – champagne being unobtainable – on the rock containing the gold-bearing quartz, and named the prospective township Barberton, after the discoverers of the reef.*

*Wilson, 1901, p36*

The discovery of gold proved a magnet for thousands of European prospectors, and the subsequent establishment of commercial mines, forestry, and agriculture over the decades attracted a large Black labour force from the nearby Swazi, Shangaan and Chopi (Mozambicans), as well as labourers from Nyasaland - present day Malawi (Myburgh, 1949). The establishment of the town and surrounding commercial enterprise would, over time, have significant influence on indigenous and migratory Black populations.

*The occupation of the area by Europeans has had -- major results for the natives which must be referred to. One is that all land may now only be owned by Europeans except in the two released areas in the extreme east of the district, which leaves several tribes of note without any land where they can live undisturbed... The other consequence of European development has been a coming and going of outside natives on a scale quite unknown in earlier times. This again has two aspects, for whilst some of them stay, others merely pass through. Some do both. There is a migratory labour force of thousands on the local mines, timber plantations, and vegetable farms. This labour force comes from various parts of Portuguese East Africa, Swaziland, and the Union."*

*Myburgh 1949 p. 9*

Of the indigenous population predating European settlement, it has been suggested that the Swazi had moved into the Lowveld area and either drove out or absorbed a prior Sotho population (Myburgh, 1949). It has also been suggested that the Swazi may have arrived in the area around 1865 following their defeat at the hands of the Sotho (Thornton, 2002). It should also be noted that, prior to European settlement, the indigenous Lowveld population is known to have existed in a rather precarious and hostile ecology, the contemporary European explorer (Erskine, 1869) describing the Lowveld as an area plagued by malaria and tsetse fly. Indeed, Hilda Kuper's (1965) ethnography of the Swazi begins with a brief account of King Sobhuza the 1<sup>st</sup> (c1780-1839) 'Skirting the tsetse fly and fever ridden Lowveld' as he migrated his people into the area of the present day Swaziland. Myburgh (1949) suggests that the tsetse fly disappeared around the turn of the century.

Following the discovery of gold in 1884, the rapid influx of Europeans led to the establishment of a proto-town. This grew rapidly – purportedly from one thousand to ten

thousand within a year (Barberton Hospital, 1985) and by the following year, miners and town residents were compelled to consider issues of health and sanitation, resulting in the appointment of a committee to oversee the establishment of a hospital. Buried within a contemporary newspaper is a line to this effect:

*Constructed as a committee of public health, their duties would embrace, in addition to provision for the sick, a wide and liberal expenditure of the public monies in taking those measures which will most affectively guard the public against the diseases whose occurrences in the certain result of carelessness and neglect of sanitary measures.*

*The Gold Field Times, December 7, 1886*

Up until this point, the hospital had been little more than a collection of rude huts and a tent.

Photograph 6: Barberton 'tent' hospital



*Photo used with permission from Barberton museum*

*The hospital building, which was situated on a rise a few yards out of the township, overlooked the native hut which was used as the jail. It consisted of a small wattle daub hut about 8 feet square, an ordinary native hut and a tent. The native hut was used for Black patients and the furniture consisted of a stretcher made of brushwood and covered by a couple of sacks. The wattle daub hut was for European patients, and the furniture consisted of two stretchers, a gin case and a candle stuck in a bottle. The tent housed the matron and served as the dispensary.*

*Adams (1884) cited in Barberton Hospital (1985)*

Three years following Barberton's founding, the 'hospital' had moved from its rude beginnings to a government-funded health facility hosting the first nurse training college in

South Africa. From its beginnings, till the fall of apartheid, the provision of health care in Barberton's hospitals have been segregated, with dedicated White and Non-White facilities.

Photographs 7: Early Life in Barberton General Hospital and 'White' Patient Ward



*Photo used with permission from Barberton museum*

Little documentary evidence exists to help form a concrete picture of African traditional medicine in the early years of Barberton and the wider Lowveld. What little I was able to glean stems from the scattered thoughts in the surviving memoirs of the previously mentioned gold commissioner, Wilson (2009), who makes some reference to African

traditional healing. As a prominent official, Wilson became acquainted with the contemporary Swazi King Umbandine (also referred to as Mbandzeni or Dlamini iv) who reigned from 1875 to 1889. During Wilson's visits to nearby Swaziland, he describes encountering the 'unnatural' beauty and youth of the king's fifty eight wives:

*... these women retained their juvenility long after the age at which the Kaffir female shows signs that her first youth had passed. The circumstances were so striking and noteworthy that I made it my business to ask for an explanation from the King's adviser. He told me that the art of preserving the youthful appearance was a royal secret practiced by the medicine men, and the brilliant results accruing from the use of this secret elixir had often been remarked upon by observant travellers.*

*I had heard of some such process of 'doctoring' as that mentioned by Steyn, and had attached no weight to it, but the sight of these marvelously preserved royal wives renewed my curiosity in the subject, and I made further inquiries into the matter. The result of my investigations satisfied me that the Kaffirs do really possess the secret of some mysterious medicine which retards the natural process of physical decay. The medicine, like all Kaffir specifics, in the product of a herb, and is administered in powder form once only, when the girl has reached a certain age. The result is apparently precisely what we are told follows the use of the traditional elixir of life. The girl retains all the outward signs of youth. Her eyes are bright, her flesh firm, her limbs shapely and supple. Not a line shows on her face, and in this condition she will remain for thirty or forty years... It must be remembered too, that Kaffir women age very rapidly, a woman of thirty looking equal in age of a white woman of fifty...*

*That the native possess the knowledge of the effect of plants utterly unknown to European science is a fact too well established to be questioned. Some of their cures are a little short of marvelous, as any man who has lived for any considerable time with native tribes can testify. Despite the growth of medical knowledge, no qualified physician can boast of such uniform success in treating dysentery, fever, snake bite, etc., as the skilled Kaffir doctor. I say 'skilled' advisedly, for there are a number of incompetent pretenders among the members of the Kaffir 'medical profession.'*

*Many white men have such faith in Kaffir remedies as a result of experience, that they will use no other, and prefer the ministrations of a Kaffir medicine man to those of a qualified practitioner in all cases of what may be termed local ailments...*

*There are treasures greater than gold and precious stones still remaining to be gathered in South Africa, and not the least of them are the marvelous secrets in the art of overcoming the apparent laws of nature and defying change and decay which the Kaffir expert possesses.*

*Wilson 1901 p. 80-84*

Wilson's account suggests that the early use of African traditional medicine was well received by European immigrants, claiming that there is a general recognition of the value of indigenous knowledge and local *material medica* - local flora, and other interventions of a physical nature – particularly by Boer farmers who apparently not only utilised the medicines of indigenous healers, but also consulted with tangoma to have the *doll oss* (bones) thrown for divining the location of lost cattle or other matters.

It is evident, in his writings, that Wilson elevates contemporary African traditional medicine above Western medicine, and emphasises the ignorance of the latter in relation to the beneficial uses of indigenous remedies. One should also bear in mind that Western biomedicine was still very much in its infancy at the time Wilson was writing. The tuberculosis pathogen had only been isolated by Koch nearly three decades prior, and it would be almost another three decades before penicillin was discovered.

On reading Wilson's memoirs, there is a clear emphasis on the romanticising of African traditional medicine, and indeed to a large extent the romanticising of the native, in particular the skill of the '*Kaffir doctor*'. However, there are other areas in the work that clearly show that the author is enamoured with matters esoteric, or at the very least is writing to an audience who is. At one point he refers to an "...*extraordinary system of secret telegraphy practiced by the Kaffirs*" where "... *Kaffirs reported events hours, even days before the news could possibly have got through by the ordinary channels.*"

*Whatever the true explanation may be, it has not been brought forward yet, and the fact remains that the Kaffirs have some means unknown to Whites by which they can transmit intelligence vast distances under conditions that preclude the possibility of their having employed any agency that we are familiar with."*

*Wilson 1901 p.85*

### **4.3 Observations of present day Barberton**

Barberton struck me as a sleepy frontier town removed from the bustle and freneticism of South Africa's larger cities. A town in which one ambles around half-expecting to cross paths with a brace of bouncing tumble weed. Time in Barberton oozed. Professor Thornton, who had introduced me to the site, provided a tongue-in-cheek, but suitably apt description of the area as a '*a drinking town with a gold problem*' (Prof Thornton Pers com). Gold mining remains one of Barberton's major industries, and I did not have to spend too much time talking to local residents to uncover that vices such as marijuana cultivation and peddling along with excess alcohol consumption and illegal gold mining are commonplace. Police are described as inept and corrupt, and the term cut-throat-politics is not entirely figurative in the province of Mpumalanga in which Barberton is situated.

Halfway through phase two of the project, I was reminded of Professor Thornton's observations as I cycled into Barberton general hospital in time to interview night-shift staff

during the quieter hours. It was one o'clock in the morning and, as I was locking up my bicycle to a lamp-post, a flat-bed police van raced up the main drive and screeched to a stop in the casualty bay dock a few meters away from me. Out of this van stumbled two swaying and laughing officers. The driver swaggered and disappeared into the emergency room to call a nurse while his partner moved around to the rear, opened the door, and struggled to extract a clearly injured man from the back. The casualty was holding on to the back of his head with one hand, and blood was seeping through his fingers and colouring the back of his once white shirt. He sat slumped with his legs dangling off the back of the van, but the law man continued to try and pry him from the vehicle. In an attempt to cooperate, the casualty staggered and stood briefly in a stooped posture, before collapsing in slow motion onto the hospital bay floor. For a moment, the police officer continued to cling to the injured man's collar, but gave up this fruitless attempt when he realised that it was only proving effective in popping shirt buttons and twisting the injured man's neck.

I walked up to the scene and enquired as to what had happened. The officer explained that this man had acquired his injuries during a drunken argument with his brother-in-law, one that ended with an altercation involving a kitchen knife. As the officer spoke, it was hard to ignore that his words floated over to me on pungent and bitter beer-laced breath. The slightly glazed look in the officers eyes spoke volumes. Before he could elaborate further, his partner in law returned from the casualty ward entrance, and both policemen staggered and stumbled back into the van, slamming the car doors before speeding off. The bloodied figure had been dumped, quite literally, and left unattended on the casualty bay floor looking not unlike an unfortunate victim of a hit and run.

I rushed into the casualty ward to get help, and tackled a nurse, who, by the look of the impressive number of stripes on her uniform, held more authority than others. 'I told them to wait for me!' she huffed, directing muttered invectives under her breath at the departing inebriated policemen. We rushed outside with a wheelchair to scoop the man off the floor and get him onto a gurney. When I spoke to the nurses a few moments later, I learned that the events I had witnessed, while not the norm, were not entirely uncommon. .

I returned outside to the casualty bay dock to ponder on the rather surreal experience. Standing in the spot where the man had lain on the floor, my eyes were drawn to the droplets of fresh blood that were quickly becoming lost amongst the scattered oil stains, and wondered, for a moment, about the importance and relevance of my project aims in the wider scheme of life in Barberton.

The 2011 census for the *Umjindi* municipality, which includes Barberton and its immediate surrounds, indicates that there was a population of 69 350 comprising 88% Blacks, 2% Coloureds, 1% Indian & Asians, and 9% Whites (Statistics South Africa, 2011). Buried within these broad race categories is an extraordinary diversity that one can only appreciate after having lived in the town for an extended period of time. Indian and Chinese general stores dot the town centre, and sit side-by-side with Black and White-owned businesses. Whites include recent and established immigrants from across the country, and indeed the world<sup>56</sup>, and the 88% Black residents, though of predominantly Swazi derivation, include people drawn from across the African continent.

Despite nearly two decades since the dissolution of apartheid, residential areas largely remain clustered into what were once race mandated locations. A White, predominantly Afrikaans, population retains a position of relative affluence in suburbs that surround the small town centre of Barberton (see blue outline on the Map on the following page). Their houses, surrounded by large gardens and resting on quiet and wide tree-lined avenues, lie on the bottom slopes of mineral rich mountains, where many enjoy a position of height overlooking *Emjindini* township and the rolling De Kaap valley basin beyond. This area enjoys excellent amenities of clean running water and a (largely) uninterrupted electricity supply, a public library, museum, a large public swimming pool, sports fields and facilities, and the best equipped schools. A history of segregated urban planning shows how such amenities were once situated close to White's-only residential areas.

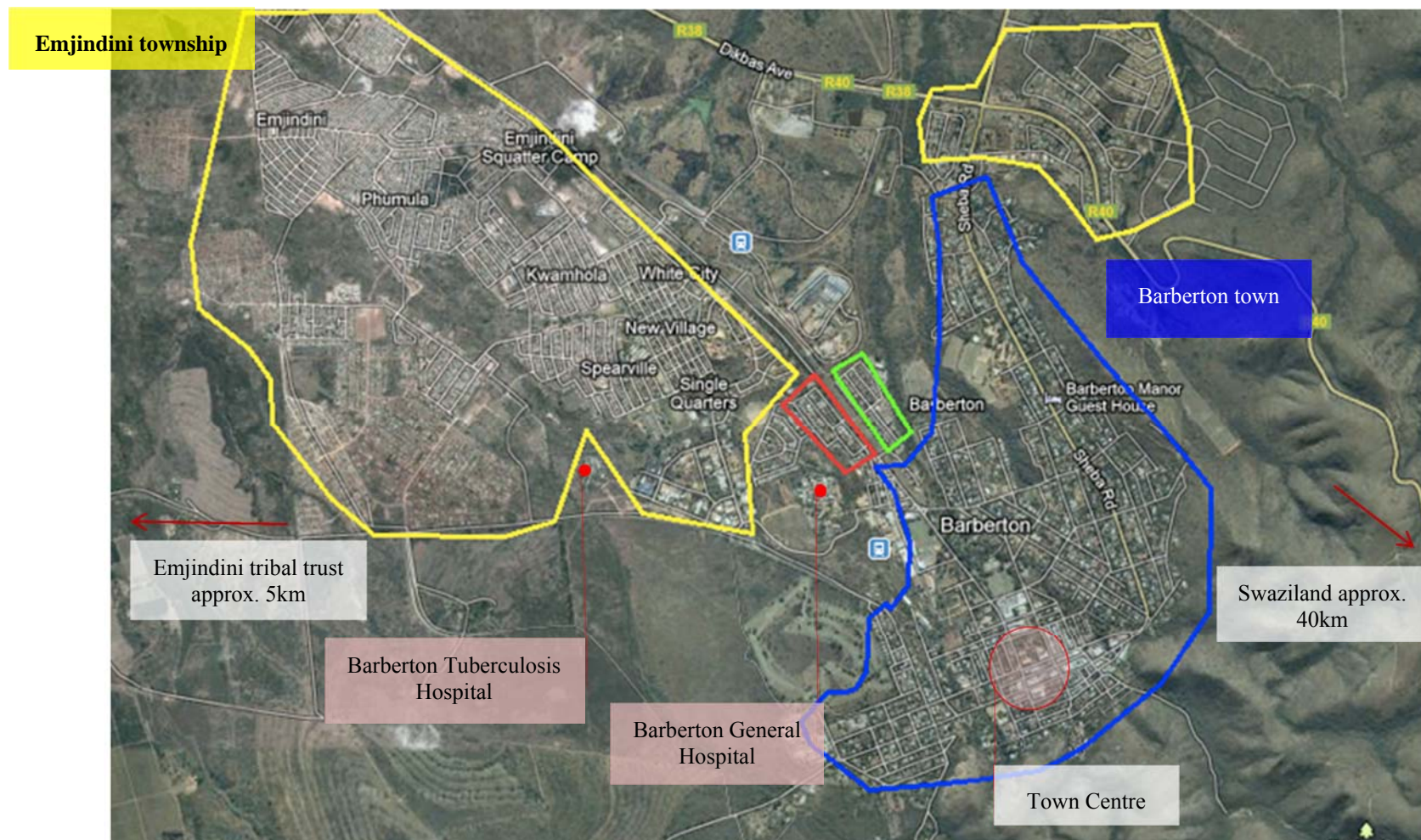
Lying directly to the north-west of Barberton Town centre, is Emjindini township (larger yellow outline on the left of the map), historically, and indeed remaining, a Black residential area. The township of Emjindini consists of a mixture of a dwellings where informal settlements sit adjacent to recently built rural development housing. Emjindini also shows evidence of a growing Black middle class where modern and affluent double story houses have been erected, and where expensive luxury vehicles can now be seen in driveways around the township, an incongruity given that rough and informal tin-and-shack housing is situated only a few streets away. While travelling through Emjindini township by bicycle, it was evident to me that this area remains significantly deprived compared to the established suburbs surrounding Barberton town centre. Large untended potholes threatened to throw me off my bicycle at every juncture, roads were in very poor condition, and the schools I passed were neglected and clearly under-invested.

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<sup>56</sup> I even encountered an expatriate Scot from Edinburgh who was now living in the town.



Photograph 8: Overview of Barberton Town





Travel between the town and the township is usually by foot or by taxi, the latter of which in South Africa means a '16' seater minibus, which, in reality, often contains far more than 16 people. However in Barberton, the taxis are not minibuses, but instead rugged and dilapidated Toyota Venture 4x4s. And I can personally attest to the dilapidation and the questionable road-worthiness of these vehicles from my own journeys in these taxis. I would try hard not to appear overly concerned about sitting on a wobbling seat, or physically holding a door closed for fear it would swing open when we careened around corners. This was all to the mirth of the other passengers who rarely, if ever, see a White jump into a taxi. I was always the only White person on board.

While Barberton town centre is the hub of services and trade. Emjindini township has a network of *spaza* stores – convenience stores selling all manner of goods from foodstuffs and household items, to batteries and blank CDs. These *spaza* shops are dotted throughout the township as standalone ventures or integrated into houses. The outskirts of the township are still expanding northwards to cater for a growing population as indicated by the presence of cleared areas of land and veld. However, it appears that government plans to provide land and housing have been too slow for many residents, as can be attested by the recent illegal occupation of municipal land, and the subsequent suit brought by the Umjindi municipality to evict the squatters (SABC, 2012)

The Indian (red outline) and Coloured (green outline) residential areas are very small in comparison to the predominant White and Black areas, and these are situated at the nexus between Emjindini township and Barberton town centre – which, incidentally, is where Barberton general hospital is situated. The smaller yellow outline north of the town is a growing complex of newer and larger houses with mainly Black residents. This area feels remote and significantly removed from Barberton town.

Lying approximately 5 kilometres west of Barberton town is Barberton tribal authority, administered by Chief Kenneth Dlamini. The area was once a White-owned farm, purchased by the state government following apartheid's dissolution, and is now settled by a sizable Black population of mainly Swazi derivation. Dwellings in the tribal trust are informal, far more rude and makeshift, with no paved roads and little infrastructure.

It was hard to shake off the feeling that Barberton town retains strong echoes of apartheid social engineering, particularly in the manner in which living areas largely remain separated by colour. However, this is only a very general observation, and while particularly true for the Black, Indian, and Coloured areas which have had little cross-racial influx, an

aspirational Black middle class has started to emerge within areas once designated as White-only. In particular, many of the Black professionals I had met in Barberton's hospitals reside in the more affluent areas approaching upper Barberton, and it is clear that the formerly White suburbs on Barberton's immediate outskirts are now also settled by Blacks. What used to be stark racial borders between races are slowly changing, and in certain adjoining areas there is now more of a gradual continuum emerging.

Any sub-urban migration, as far as I can tell, is only one-way. On my occasional jaunts through Emjindini township, in particular my walk to the taxi rank situated at the main entrance to the township, I would invariably always be the only White person waiting for the taxi, and would draw stares to that effect. The only other Whites I encountered within the Emjindini community were Professor Thornton and two of his staff running a local project, and an American peace corps worker who had, for the last two years, been teaching science in Emjindini's poorer schools. While Blacks move freely in all parts of Barberton town, this corollary is not true for the township. Indeed, I feel there is a perception amongst many Whites in the town that the township is an area somewhat off-limits. When I recounted my forays to White residents in the town, mentioning that I had caught a taxi to the township and then on to Nelspruit, I would sometimes be on the receiving end of a caution that the Location was not an entirely safe place for a White to be, and that getting into a taxi was playing Russian roulette with my life. Even Black nurses in the hospitals would express some concern for my movements, and, on more than one occasion, I was drawn aside and spoken to by nurses who were concerned that I was riding around Emjindini on a bicycle. I was strongly advised to stay away from the township at night for the reason that there were too many drunks on the streets. In comparison, the streets of upper Barberton were all but deserted at night. In this, there is a very different atmosphere between Barberton town centre and Emjindini township.

While the above description of Barberton has little bearing on matters of medical pluralism, it does, I hope, outline the town's racial and demographic contours. While I did not set out to explicitly explore issues of race, it was quite evident that racial matters still permeate much of Barberton life, and I did happen to encounter the odd pocket of tension and discord both in the town and within the hospitals themselves.

One afternoon, Nurse Dlamini, who I had befriended early in my research, raised an issue with me over lunch in one of the general hospital's enclosed courtyards. We were talking about that perennially interesting subject, politics. We discussed the 'modern' ANC and the

recent events surrounding a civil servant strike that had occurred only days prior to the start of my second phase in the field. Our discussion eventually moved onto issues of race, and with an irritated look, she proceeded to tell me how some of the Afrikaners in the town remain intractably racist, and fiercely resistant to the change that had swept the country two decades earlier. She continued by explaining that she had two children in the junior school in upper Barberton, a school that once catered exclusively to European children. I had cycled past this school on many occasion and knew it to be the best resourced junior school in the area. It was clear she took pride in the fact that her children were attending a good school, one that she herself was unable to attend whilst growing up. Also, she was proud that she was in a position to give her children a premium education.

She continued, relating a story of how she was called into a parent's meeting the day before, to discuss a request by a group of Afrikaner parents that their children be taught separately from the 'rest' of the children in the school, and she pressed me for my opinion on this matter. I replied that the very symbolism of such a request would, on the surface, sound very close to the 'old' South Africa. I asked her for the reasons behind the request, and she explained that the Afrikaner parents had emphasised that it was not a racial issue, but instead they wanted the children to do all their subjects in the Afrikaans language only. Nurse Dlamini pounced on this as being a poorly disguised pretext. *"I just don't understand."* She said. *"What is wrong with these people? Do they think we're stupid? Do they think we don't see that they are trying to create a new apartheid within the school?"* She went on to say that she had no problem with her kids learning Afrikaans and English as second and third languages, making the suggestion, one that is not entirely beyond the pale, that White children should now start learning Swazi. *"They're quite happy being racist, and quite happy to bring their children up as racist."*

Though I do not consider matters of race a significant focus of this thesis, it is nonetheless difficult to ignore. And indeed, in many respects I was compelled to confront my own ideas about the politics of race in South Africa, particularly with regards to racial terminology. As an example, I was surprised to hear that many people I spoke to, regardless of colour, still referred to Emjindini township as the *Location*. I should explain that the term *Location* and township are essentially interchangeable, though whether there is any pejorative meaning attached to either word is still up for debate. The term *Location*, or the Afrikaans derived slang *Kasie*, is an apartheid era term that, for me at least, still resonates with deep-rooted connotations of illegitimate coercive power. Power exercised by an unrepresentative government that engineered physical and spatial restrictions for living. And I confess that I

am somewhat uncomfortable when this word is used, almost as if one is using an unacceptable racial epithet.

When I struck up conversations with Black residents, they would often make reference to the Location, and I admit to feeling somewhat uneasy whenever they did so. Why could they not just say Emjindini? Do they refer to the Location, or to Emjindini when talking to other Blacks? When I eventually asked one of my informants why she referred to Emjindini as the Location, she was somewhat puzzled. When I disclosed to her that the word, for me, evoked memories of apartheid, and the history of the forced location and restricted movement of Blacks, she took a moment to think over my own impressions, and concluded that it was a term that she had grown up with, and that, for someone who lived in the Location herself, it did not evoke the same emotion or impression.

On reflection, the negative emotions this word elicits, stems not only from the apartheid notions of oppressive power, but is also evoked by my childhood in which I was constantly cautioned about the dangers of *the Location*. An area in which it was unheard of for a White, in my own social and familial circle, to venture when I was growing up. The Location was as off-limits to Whites as White suburbs were to Blacks. That early conditioning I received as a child appears to have reached across the years, so much so that I was never entirely comfortable travelling through the Emjindini township. In truth, I was far more comfortable traversing the villages in the mountains and hills of KwaZulu Natal, than I was within the suburban landscape of Emjindini.

A further instance in which I encountered a more overt use of terminology that speaks to racial politics in post-apartheid South Africa, comes directly from within the medical establishment itself, and was directed by one doctor towards another. I hesitate to raise this particular issue, and because of the nature of the matter I am providing a heavily redacted version of the account, with no identifying characteristics of actors involved.<sup>57</sup>

This account concerns a White doctor expressing dissatisfaction with the work and skills of a Black colleague. The former, apparently, had to intervene to rectify a decision that had been made by the latter that purportedly would have placed a patient in harms way. The White doctor did not discuss specifics, but hinted that the problem revolved around the incorrect prescription of a drug, and that only by double-checking this colleague's decision, had a

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<sup>57</sup> It has been difficult to write this account for the simple reason that I do not want to stoke controversy and tension between individuals within the research sites. Though it is unlikely that what I am about to raise is not already an issue of open contention and discussion, nonetheless, I have omitted any characteristics of the doctors involved including gender, age and position and whether they worked in private or public practice.

potentially life-threatening event been averted. The Black doctor supposedly responsible for the incorrect prescription was then referred to as an inept “... *affirmative action doctor*”. By this, the White doctor was making reference to the contentious post-apartheid policies of positive discrimination where South African medical schools now have a reserved quota of places for students from previously disadvantaged backgrounds. Specifically, the post-apartheid government wants the medical student body, and subsequent medical professional body, to roughly reflect the demographics of South Africa at large, with roughly 75% of students drawn from the Black population. This policy has been incredibly controversial and divisive, and one that is periodically resurrected in South African medical journals (Benatar, 2010), as well as wider local and even international news (Dugger, 2010; Grobbelaar, 2011; Myburgh, 2007). The knock-on effect of this policy has been that the limited number of places open to White medical school applicants requires those competing to have achieved extremely high A grades, whilst Black students applying for admission apparently need only achieve comparatively much lower grades to satisfy entry criteria. This policy has fed directly into stereotype arguments on the relationship between race and intelligence, particularly by those who would gesture to these policies as ‘evidence’ that Black Africans require state intervention to achieve entry into a profession that Whites enter solely on merit.

The White medic who used the phrase *affirmative action doctor* to describe their colleague, was expressing frustration that the person in question was not suitable doctor-material in the first place, and was practicing only by the grace of positive discriminating policies. The White doctor was linking this directly to the lowering of standards for Black students entering medical school, however, the White doctor in question was also careful to emphasise that the phrase *affirmative action doctor* was a criticism of a political rather than a racial nature: “*There are Black doctors here I respect enormously, who are brilliant at what they do. They would have gotten into medical school anyway, but [X] is not one of them.*” Issues with the doctor who was on the receiving end of this criticism also happened to emerge in discussions with other informants, with another medical professional drolly joking: “*I’ve told my wife if I get into car crash, and you see its ‘X’ on duty, just get me the hell out.*”

The brief overview of the account, pruned as it is of identifiable characteristics of individuals involved, did raise challenges that speak to the ethics of research methods. Participants who raised the above issue quite obviously wanted the matter to be raised, and I, as a researcher and not allied to the institution, was rather conveniently placed as a listener. Many medical professionals, regardless of colour, would talk of African traditional medicine in a vein of

controversy, and for some, this opened the door to raising and discussing whatever else they felt was a relevant controversial issue. In this regard, I felt that to some extent my interviews and discussions were sometimes approached by informants and participants as more of a journalistic rather than academic endeavour, and the above account was a classic example of this.

There are further ethical issue I am attempting to navigate by including the above account. I have omitted many details, and indeed many supporting accounts in the anecdote, only because I feel that some of the information was imparted because the rapport I had established with some informants had strayed into a territory of friendship. Were I to expand further on the above account, I feel I would face a number of ethical quandaries as a result. Were people imparting information only because a researcher / informant relationship had strayed into a territory of friendship? Would I be none the wiser of political and professional tensions had I maintained a far more rigid 'researcher' position?

There is also another dimension to this ethical conundrum, and that was whether I was expected to do anything with the information provided to me. However, I did not at any point see my role as becoming involved with institutional politics. And importantly, with respect to the above case, I am in no way qualified to make a judgment on a doctor's fitness to practice based on hearsay or otherwise. Furthermore, I was already encountering resistance to the undertaking of interviews precisely because some participants felt that there were ulterior motives to my presence, and I certainly did not want to engage in any institutional politics that would fuel this misapprehension.

### **4.3     *Therapeutic Avenues in Barberton***

The Barberton area is home to a diverse range of practitioners who claim knowledge and skill at diagnosing and addressing spiritual, psychological, and physical ailments. Physiotherapists, doctors, dentists, nurses, psychologists, homeopaths, crystal and energy healers, chiropractors and of course traditional herbalists, prophets and faith healers, *tangoma*, and *tinyanga*, are all woven into a complex tapestry of medical pluralism.

Barberton general hospital and Barberton tuberculosis hospital serve as the larger public health institutions, and along with these are several smaller community-based satellite clinics – *Cathyville* in the Indian and Coloured area, and *Ma Africa* in Emjindini township. Private

family practices exist in all areas of the town and township, however, whilst there is significant movement between Emjindini's private practices and the larger public hospitals, patients seen by the town-centred general practitioners will usually have medical aid, and will be referred to the nearby Medi-clinic, a private hospital based on the edge of the town, for more serious health issues.

People interested in exploring non-biomedical health avenues need only begin by taking a short walk through Barberton town centre. It was here that I was handed a leaflet on services offered by 'Dr Norman from East Africa'; came across the practice of the inyanga Dr Zama; and saw posters and flyers plastered over lampposts and walls throughout the town advertising 'male sexual enhancement' and 'safe abortions' with no side effects. And all of this situated only a few blocks away from family practices and Western pharmacies. Indeed the latter even stocked all manner of packaged homeopathic, and even some local 'traditional' remedies, alongside prescription and over the counter pharmaceuticals.

Photographs 9: 'Health' and 'Intervention' advertisements in Barberton town centre



Source: Author's own photographs



Source: Author's own photograph

It was also evident that Barberton had a great many healers that weren't Swazi *tangoma* or *tinyanga*, as the area plays home to many itinerant, or established healers who come from outwith South Africa and Swaziland. Dr Norman from East Africa, claims to be a healer from Mozambique and advertises himself as a member of the *Professional Herbal Preparations Association of Inyangas (pty) Ltd*. While sounding official, this *Ltd* association also conveys the impressions of being associated with a for-profit, rather than a regulatory body, and indeed the association is registered not in East Africa, but in Johannesburg.

Dr Phiriherbalist is based in Emjindini township, and is a syncretic healer combining philosophies from both Islamic and African traditional healing. His home made banner depicts snakes, calabashes, and two witches riding a broom stick – a decidedly Western depiction of a Witch – and he draws clientele from both the African and the local Muslim community. Stories abound from my interviewees and informants that healers from Zimbabwe, Mozambique, and other African states, regularly come through Barberton, and it appears that their 'foreign' medicines and methods are highly valued. Indeed, it is not merely foreign healers that are valued, but as my informants suggests, a premium is placed on medicines, knowledge, and skills that are sourced from across borders.<sup>58</sup>

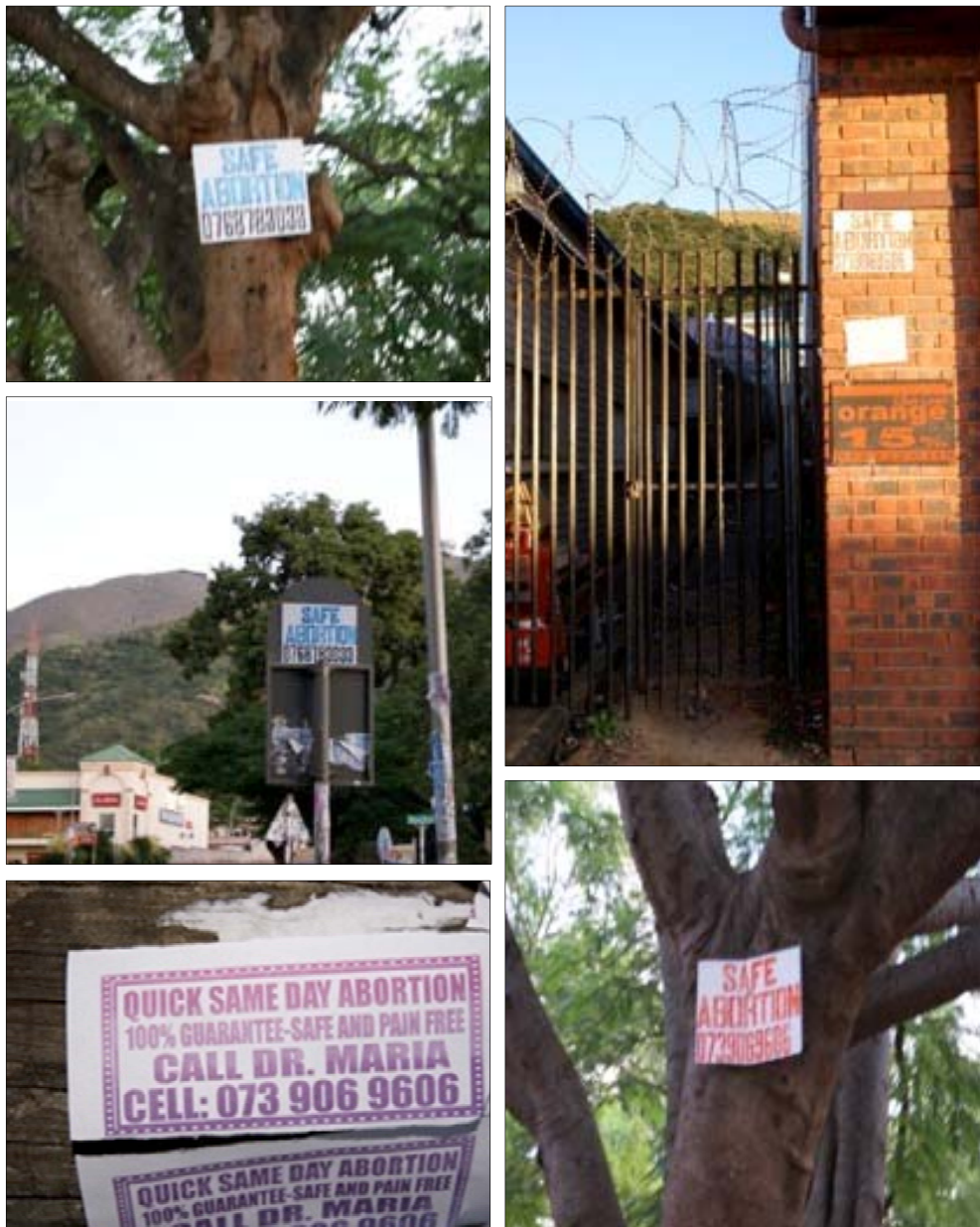
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<sup>58</sup> This crossing and leveraging of both geographic and figurative boundaries, where healing and its value are intimately tied in with the traversing of boundaries and states, and indeed spiritual boundaries, has been discussed at length in the edited volume, *Borders and Healers* by Luedke and West (2006).



One thing that did strike me as interesting whilst walking around town, were the numerous advertisements, flyers and billboards advertising ‘safe’ abortions. These can be found on street corners, lampposts, shop walls, and interestingly, very high up in tree branches. These roughly painted advertising boards and leaflets can be found throughout the town center, and lining the lampposts and street signs of the well-trodden road linking Emjindini township with Barberton town centre.

Photographs 11: ‘Safe’ abortion adverts around Barberton Town



*Source: Author's own photographs*

Whilst walking around the rows of shops situated almost directly outside Barberton general hospital, it was by chance that I came across a range of ‘traditional’ looking remedies. These were packets of coloured crystals, powders, and bottles of suspicious liquids, many promising some sort of male sexual enhancement, and these were situated in an unlikely position in the window of a hardware store.

Photographs 12: ‘Traditional’ herbs and powders in a hardware store window



*Source: Author's own photographs*

The owner of the shop, recognising my interest in the herbs, informed me that a family member of his, along with a *sangoma*, managed a traditional herbalist store on the road parallel to, and backing onto the hardware store, and I was soon whisked around to *Barberton Muti Store – specialist in African Muti and Herbs*.

Photograph 13: Muti store situated close to Barberton General hospital. (external)



*Source: Author's own photograph*

Once past the austere gated entrance, this herbalist store was a riot of colour, and appeared to be a one-stop-shop for lay customers seeking well known remedies sold over the counter, as well as traditional healers looking to buy clothing, beads, ingredients for muti, and other articles of the profession such as bone-sets for *tinhlolo* (bone-throwing divination). The particular sets placed in front of me were on sale for a 'special price' (to me) of R1500 (approx. £125), and are marketed as originating from the seas along the Mozambique coast.

Photograph 14: Muti store situated close to Barberton General hospital. (internal)



*Source: Author's own photograph*



Photograph 15: Muti store (internal), Beads and Bark



*Source: Author's own photograph*

The muti store was a visual riot, and I was not entirely sure where to rest my eyes. Every square foot of the shop contained densely packed visual information. Traditional herbs and collected barks are sold in roughly labelled packets. Colourful powders in bottles brought to mind the Hindu festival of Holi, and indeed it made me wish I knew the spectrum of colour significance within the *tangoma* and African philosophy. 'Traditional' remedies are also branded and sold in modern packaging, put together by someone with a keen eye for product placement and an understanding of both vertical and horizontal product lines. Whoever had put the product lines together, was clearly trying to leverage the commercial potential of the concept of 'traditional remedies' - much like 'natural remedies' are now standardised and can be found on the shelves of Holland and Barratt's, and equivalent stores in the UK.

One of the more frequent criticisms of African traditional medicines by biomedical professionals was that they were unstandardised and untested. It is evident that many of the products sold in the herbalist store were designed to convey this very impression of standardisation, a combining of the modern with the traditional, much like I encountered with Zeblon Gwala and his *uBhejane* concoction discussed in the opening foreword chapter. (see Marsland, 2007)

Photograph 16: Muti store (internal) sangoma paraphanalea



*Source: Author's own photograph*

To say that this was a distinctly 'traditional' herbalist store is, however, misleading, as indeed this requires a definition of the concept of traditional which, as already stated, is a concept that is continuously reinvented.<sup>59</sup> It would be more accurate to describe the herbalist store as eclectic, containing unrefined 'herbal' or 'natural' ingredients; refined or having the appearance of being refined ingredients of a 'traditional' derivation; modern pharmaceuticals that can be obtained over the counter from any official pharmacy; and a range of remedies that purportedly stem from other cultures, particularly South Asia.

Looking around the shelves of the store, it was quite easy to pick out a number of common over-the-counter remedies one would normally find in a modern chemist. Popular brand names such as Gaviscon, Rennie, Brooklax, Alergex sit alongside shelves of modern packaged and well-marketed 'traditional' remedies that clearly evoke something more 'African'. *Isihlambeza* used as a traditional pregnancy remedy, *idhliso* relating to poisoning associated with supernatural witchcraft practices; a variety of laxatives; and bottles of sea water from the Mozambiquan coast. Some boxes and bottles also clearly depicted gods from the Hindu pantheon, and '*Sanjay's*' remedies – clearly a South Asian branded product, was lined up right beside the '*Sangoma's*' branded product line.

Two people attended to the shop, the traditional healer, and a young Muslim man in his mid-twenties. The former I observed dealing with customers coming in to purchase basic and unrefined traditional remedies, and in doing so he would dispense advice and directions to Black clientele. The latter I saw attending only to patrons when the sangoma was busy.

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<sup>59</sup> See also the brief discussion of 'traditional' as a contested notion in the literature review.

Photograph 17: Shelf of 'traditional' over the counter remedies (I)



*Source: Author's own photograph*



Photograph 18: Shelf of 'traditional' over the counter remedies (II)



*Source: Author's own photograph*

It appears that some of the ‘medicines’ within the shop were not strictly for healing purposes. When I asked the traditional healer behind the counter as to the purpose for the wicked arachnid looking seed-pods that were sitting in a plate on the glass counter, the explanation given to me by the sangoma was that the seeds were used in some retributive manner. They were to be used against people who you wanted to harm, because they had done harm to you. I could not help but reflect on Ashforth’s (2005) position that the difference between the *abatsakhathi* (siSwati: witchdoctor) and the *sangoma*, is essentially a position of morality. Both are claimed to engage in the esoteric and supernatural, though to different ends.

Photograph 19: ‘Retribution medicine’



*Source: Authors own photograph*

The variety of therapeutic avenues in Barberton are extensive enough to warrant a study all on its own. The preceding pages have been purposely brief, as they are meant to convey enough of an impression of the Barberton town, and the various therapeutic avenues available so that the complex shape of the therapeutic landscape is realised. In the section that follows, I turn to outlining the two hospitals which served as research sites.



Photograph 20: Overhead view of Barberton's hospitals



Source: Google Maps

#### **4.4 Overview of Barberton's public hospitals**

##### **4.4.1 Barberton Tuberculosis Hospital**

Barberton Tuberculosis Hospital had until very recently been managed by the South African National Tuberculosis Association (SANTA)<sup>60</sup>, but by the time of my initial visit had been purchased by the state and was being administered by the Mpumalanga Department of Health. The hospital is situated on the periphery of the town adjacent to an industrial complex that, among other things, includes an engineering and scrap metal yard, a chemical manufacturing plant, and a large-game taxidermist. The hospital is situated off the umbilical road linking Barberton town with Emjindini tribal trust<sup>61</sup>.

Photograph 21: Overhead view of Barberton Tuberculosis Hospital and surrounds



Source: Google Maps, Barberton, South Africa, -25.780423, 31.027983

<sup>60</sup> SANTA is a non-profit organisation founded in 1947 around which time Barberton tuberculosis hospital was established. Despite a recent change of ownership into public hands, the hospital is still widely referred as SANTA.

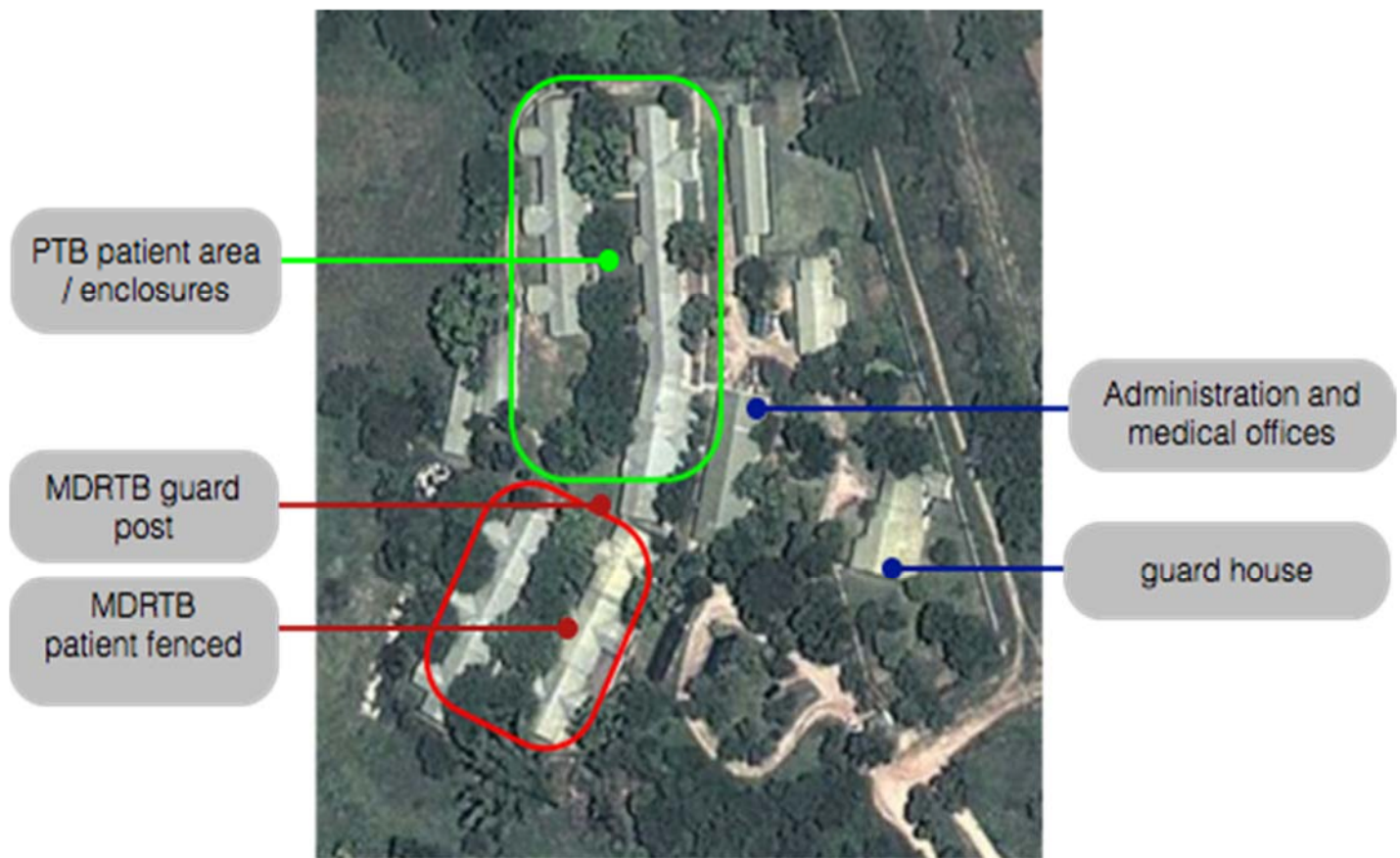
<sup>61</sup> While Barberton essentially resides within South Africa's borders, the tribal trust is administered by the local Swazi Chief Kenneth Dlamini, who administers this under the auspices of the Royal Swazi Chieftdom. The complexities of traditional authorities spanning national boundaries has been explored by Thornton (2002) who finds significant and enthusiastic community support for Swazi tribal governance in the local area.



A deeply pitted and water-eroded dirt road leads up to the tuberculosis hospital's guarded and gated entrance, and a cast-concrete wall topped with rusting coils of tetanus-inviting razor wire encircles the entire complex. The enclosed and guarded facility is a collection of several single-story buildings that observe a clear separation between administration and patient areas. Four blocks labeled A-D, each containing three nightingale wards, are built in the shape of a chevron with a central tree-lined lawn serving as a patient-communal area.

Whereas on my initial visit the hospital was separated into two separate male and female sections, by the time of my final visit two years later it had been further divided, now comprising four distinct areas - the Primary TB (PTB) treatment area, and a fenced-off internal enclosure containing patients with Multiple Drug Resistant TB (MDRTB). Both the PTB and MDRTB areas were then further separated into male and female wards.

Photograph 22: Overhead view of Barberton Tuberculosis Hospital



Source: Google Maps

On my first visit to the hospital I found myself navigating my way through lush, verdant, and well-tended grounds where impeccably neat flower beds encircled the administration area. My initial impressions were of surprise at being confronted with an ostensibly calm and tranquil atmosphere that was a far cry from the riotous and chaotic grounds of the nearby General hospital.

Photograph 23: Administration and medical block



Source: Author's own photograph

The ordered surroundings were a stark contrast to where the hospital was situated, surrounded by thorny *bosveld*, and it did not take long before the 'peace' of the facility was punctured by the rumble of heavy plant moving to and from the nearby scrap and engineering yard. Furthermore, it was apparent on close observation that some of the hospital buildings were in advanced stages of dilapidation, and verging on condemnation. The vestiges of an initial impression of tranquility were quickly disabused when I caught sight of the encircling barbed-wire-topped wall peeking through the branches of the arboreous grounds.

Past the administration offices, and within the central recreation area, mature jacaranda trees line the entire length of the grounds, with benches scattered throughout for patients to rest and congregate. However, few patients lingered under the sun, with most resting on their beds, or under the shade of encircling verandas and covered pathways, letting the cool concrete-slab floor draw away unwelcome heat.



Photograph 24: The walkway between the administration and patient wards



Source: Author's own photograph

Photograph 25: 'Male' block, later converted to the MDRTB wards



Source: Author's own photograph

Photograph 26: 'Female' block, later converted to shared male/female wards



Source: Author's own photograph

When I entered the wards I was left with the impression of an army barracks, or indeed a boarding school. The layout and the creaking metal beds, the iron-framed windows and the slowly oscillating fan evoked spartan impressions. And given that the minimum time spent in the facility by any patient is 3 months - there was surprisingly little in the way of personal effects that would distinguish a personal space.

Photograph 27: 'Female' block Nightingale wards



Source: Author's own photograph

The tuberculosis hospital is staffed by a full-time medical manager, two part-time sessional doctors, and a full-time occupational therapist. Two senior matrons manage a fluctuating nurse staff of around two dozen, however, the nursing team is significantly understaffed with approximately half of the posts unfilled.

The administration and management team suggest that staff shortages have arisen for a number of reasons. Firstly, there are inherent difficulties in recruiting staff to work within the tuberculosis hospital, the biggest challenge being the associated stigma, and of course the occupational risks - the very real possibility of nosocomial infection (O'Donnell et al., 2010).

*My family doesn't like it that I work here, they would prefer it if I was at MA-Africa [Emjindini clinic]. Even my kids are embarrassed to tell their friends I work at SANTA.*

*Nurse Pitso*

*You know, it's not a difficult job in the sense that it is physically demanding or very complex. It's just that there's such a great deal of stigma associated with working here - and of course, they [nurses] are scared they will get TB themselves. We have had nurses in the facility get TB and they land up as patients in here, and it's a small town hey. Word travels fast.*

*Carolyn, occupational therapist*

Secondly, the Mpumalanga Department of Health requires that all posts created by departing staff need to be centrally advertised by the government. And despite repeated requests, and constant attrition since the hospital was taken over by the Provincial Government, empty posts have never been advertised. Hospital administration puts this down to a combination of gross ineptitude and rampant corruption on the part of the provincial government.

The role of nurses within the facility is multifaceted including administering and observing patients taking their medications, seeing to everyday needs, helping those too weak to navigate around the hospital, and helping patients comply with required treatment protocols. Nursing stations are situated within each ward meaning that patients theoretically have a ever-present source of help when needed, or indeed to put it another way, patients are under constant observation.

When patients are admitted into the hospital following a confirmed sputum test, they are assigned a bed and bedside locker for personal items. A hospital induction and orientation programme that follows serves as a starting point for educating patients on TB & HIV. During this induction patients are made aware of the rules and regulations of the facility,

medication times, exercise time, meal times, and the structural features of institutional life with explicit prohibitions on alcohol, *dagga* (marijuana), sharp instruments and guns.

In theory, each patient is allowed one ‘pass-out’ each month where they are permitted a weekend or an afternoon from the facility to see family and friends. However, this can only be granted under the provision that the patient poses no immediate danger to society. This is measured clinically by a monthly-administered sputum test which needs to indicate that a patient is no longer infective. However, I also came to discover that this pass-out is also provided on the condition of patient behaviour where measures of good behaviour are directly linked to adhering to the already mentioned rules and protocols, but, importantly, also complying strictly with treatment.

Barborton Tuberculosis Hospital strongly resembles a carceral institution, and I draw this equivalence from my impressions of the design layout, the guarded gates, the razor-wired concrete walls, and the ‘exercise yard’. Further is the expectation that those interred comply with strict rules and regulations which include restrictions and control of movement and access, and indeed benefits such as monthly pass-outs being contingent on ‘good behaviour’. In effect, individuals are required to submit to a daily routine, are encouraged to learn about their dysfunction and affliction, and required to submit to a period of state-controlled corrective measure following which they might be deemed fit for release into society. Furthermore, the approach to tuberculosis treatment focuses a great deal on patient behaviour. Indeed, the biomedical establishment has a history of labeling patients using terminology evoking notions of deviance - i.e. patients are potential defaulters, compliant or non-compliant, adherent or non-adherent (see Greene, 2004; and Harper, 2010).

My impressions of the TB hospital as a carceral institution was reinforced by the sight of patients ambling around the grounds shrouded in threadbare and ill-fitting pink or pale-blue pyjamas, sometimes with **BARBERTON TUBERCULOSIS HOSPITAL** stencilled on the back in one-time-red, now wash-worn pink lettering. Upon entering the facility, patients are required to relinquish personal clothing for this regulation hospital wear that, while practical and utilitarian from a clinical perspective, is nonetheless depersonalising. De-individualising and stigmatising patient uniforms have previously been likened to uniforms of other ‘state-regulated’ or ‘captured’ bodies – i.e. prisoners or members of the armed forces (Helman 1990). Indeed, one cannot help but view the function and form of the tuberculosis facility through a distinctly Foucaultian / Benthamite lens of surveillance, and drawing similarities



between the hospital and the nearby Barberton prison – also sited on the margins of Barberton society.

Photograph 28: BTH. Remembrance and prayers on 'AIDS' day



Source: Author's own photograph

These are not merely austere garments shrouding diseased bodies, but uniforms redolent of stigma - a uniform denoting state-sanctioned biomedical control, and affording the wearer membership-status to a community of affliction. Those wearing the uniform perched in the borderlands, a liminal state of existence awaiting re-entry into society, whilst all the while musing on the alternative existential threat. That the institution is a complex site of control and correction, is, in my opinion, beyond question.

The treatment of tuberculosis, especially the emergent drug resistant variant of the disease, is complex, and indeed this is one of the reasons raised by nurses as to the need to ensure that patients are brought into an institution where they can be monitored for their apparent 'own good'.<sup>62</sup>

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<sup>62</sup> These reasons are often evoked, however, despite this, experts have suggested that tuberculosis treatment be administered through decentralised clinic-managed community rather than in large carcerate facilities (Edginton, 1999; Heller et al., 2010)

#### **4.4.2 *Barberton general hospital***

Whereas Barberton tuberculosis hospital is situated on the town periphery, isolated from the bustle of everyday life, Barberton general hospital sits just off a busy junction that joins Barberton town centre with Emjindini township. The area outside Barberton general hospital is alive with the constant buzz of traffic, with taxis racing down streets and around corners, people queuing for buses, and peddlers trying to sell fast food to passing visitors. A complex of Chinese, Indian, and African-owned shops that include wholesalers, general stores, cafés, and indeed the aforementioned ‘traditional’ muti store, lie adjacent to the hospital’s entrance.

Photograph 29: Overhead view of Barberton general hospital



Source: Google Maps

I would usually cycle past the near empty roads when travelling towards the tuberculosis hospital, being careful to dodge the scrap metal puncture-hazard detritus from the mechanics yard. However, when travelling to the general hospital I would usually find myself dodging traffic and people. There are guards posted at the boomed entrance of the general hospital, though their job appears to revolve largely around controlling vehicular access, as

pedestrians are freely able to pass through the open gate situated directly next to the guard post.

Barberton general hospital is a far more complex organization than the nearby tuberculosis hospital. While the TB hospital is essentially geared to address one single disease, the General hospital, with more than three hundred beds, hosts a number of departments – paediatric, dedicated medical and surgical wards, obstetric and maternity wards, outpatient facilities, and a casualty ward to name a few. Also included is a radiology unit and laboratory facilities, a centre dedicated to HIV / AIDS treatment and support, a small counselling and psychology unit, a large dispensary, and a social work unit. All these are supported by a large administration and records department that manages the paper based records system of dusty ledgers and brown patient files. Barberton General also runs an on-site nurse training facility, incidentally the first nursing training school in South Africa, and trainees can be seen throughout the hospital. Indeed, many of my interviews were conducted within the secluded, and somewhat worse-for-wear repurposed ‘lecture’ rooms that still retained defunct and decades old apparatus and wall-mounted fittings, a testament to the room’s initial intended use as a patient ward.

Whereas the tuberculosis hospital was a relatively simple structure to navigate, and where most activities took place within a central courtyard, the general hospital was a far more complex built environment, and thus a far more complex institution to navigate for research purposes. I would often wander around the facility, trying to get my bearings, and frequently felt like the hospital was far too large to cover as a single researcher, resulting in numerous field notes expressing frustration at feeling spread too thin in this institution. The facility was sprawling, having been built up and added to over the decades until the current hospital did not quite resemble a purpose-built modern facility with a coherent layout, but rather a collection of units and wings, stitched together with stretching corridors of varying states of disrepair, and barely plastered over to provide a thin veneer of architectural continuity. I was able to see much of this veneer peeled back, as my time spent in the general hospital coincided with a significant capital investment from the Mpumalanga Health Department. During the first two phases of the project, I was stumbling along with patients, nurses and visitors through a torn up car park just to get to one of the hospital entrances. My interviews would be held with the background cacophony of jackhammers, heavy machinery, the shouted directions of carpenters and builder, and I would leave every day grateful of escaping the dust and commotion, lamenting the plight of patients trying to rest and recover amongst a building site.

The physical structure and layout of Barberton general hospital differed significantly from that of the nearby TB hospital. The TB hospital is a relatively confined and heavily controlled space that, as I have previously alluded, resembles a prison facility. It is entirely inward looking, and its shape and structure leads the observer's gaze to focus inward on the events occurring within the centre of the facility where patients generally congregated in the communal yard.

The general hospital was not built with these Benthamite panopticonesque and Foucaultian echoes in mind, but instead was a sprawling facility, with limited field of vision, branching corridors at odd angles, and dead-end walks. Whilst the tuberculosis hospital was run at a relatively sedate pace, geared as it was to treating a single disease, and with staff essentially having to mechanically perform much the same function on a daily basis, Barberton General Hospital was a hive of activity and uncertainty. Doctors and nurses scurried around halls and between buildings, patients and staff huddled in scattered courtyards to sneak a smoke, and I would often find lost patients and visitors wandering the warren of confusing connecting corridors, and trying to make sense of the collection of new and old signage in their attempts to map a path through the hospital. After a few weeks, I became quite adept at helping redirect lost visitors.

I should also mention that both state hospitals cater almost exclusively to the local Black population. At no time when I visited the tuberculosis hospital did I see a patient who was not Black, though the managers of the facility assured me that the odd Indian, coloured, or White person did find their way in. That tuberculosis largely remains a problem for South Africa's Blacks is a testament to the longevity of the country's political, economic, and structural problems (see Packard, 1989) in which despite the dissolution of apartheid, a marginalised Black labour force largely remains at the mercy of the disease. The General Hospital was slightly more diverse, where I would on occasion see White-Afrikaans, Coloured, and Indian patients and families wandering the corridors, where their presence indicated an inability to afford private health insurance.<sup>63</sup>

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<sup>63</sup> Indeed, when I suffered my own bicycle accident in the field, I was driven to the hospital by a young White man, who, upon helping me into his car, immediately started driving towards the private Medi-clinic. I had to insist several times that I be taken to Barberton General Hospital. "*Are you sure you want to go there.*" I could pick up the incredulity in his voice even while lying bleeding and in shock on the back seat of his car.

#### **4.5     *Summation***

The purpose of this chapter has been to provide a descriptive overview of Barberton and the two hospitals at the centre of this study, as well as providing a very brief overview of the other therapeutic routes available to patients. While serving to ‘colour-in’ the background, the overview also raises significant questions, particularly on how different therapeutic routes and notions articulate within the biomedical space. These, of course, I reserve for the findings-chapters. The chapter that follows, however, builds upon the previous two by discussing in greater detail the process of fieldwork.

## ***Chapter 5: Barberton General Hospital***

### ***5.1 Chapter Outline***

This chapter presents findings from Barberton General Hospital, and explores nurses and doctors' experiences and perspectives on African traditional medicine, and its emergence within biomedical spaces.

Part 5.2 provides an account from within Barberton General Hospital that illustrates many of the social, cultural, and political issues that emerged. This reflective introductory account illustrates some of the challenges of researching this topic in a post-apartheid public institution.

Part 5.3 provides an overview of respondents within Barberton general hospital, emphasising the diversity of views and beliefs held by the medical-staffing body. This section also discusses some of the initial challenges of interacting with participants.

Part 5.4 highlights the ways in which traditional medicine is said to appear in the hospital, outlining how doctors and nurses typologise their encounters. I also explore the perceived challenges and complications of what is largely, though not always, described as an unwelcome infiltration of African traditional medicine into the biomedical space.

Part 5.5 examines the role of nurses as culture brokers who are embedded at a juncture between professional and personal cultures and expectations, and where they are required to navigate and mediate conflict arising from their positioning.

## 5.2 *Navigating perspectives*

*'It's just primitive'* remarked the young White-Afrikaans doctor as we sat having lunch in one of the many scattered courtyards at Barberton general hospital. With phase two of the fieldwork largely behind me, I was no stranger to encountering negative views on African traditional medicine, though admittedly, such views were usually conveyed with a great deal more subtlety, and usually in a private setting.

Unlike many of her colleagues, this experienced doctor had resisted the temptation of a more lucrative career in the private medical sector, and had spent the better part of the last decade toiling away in the challenging environment of South Africa's public hospitals, administering to a largely poverty stricken population unable to afford private medical insurance. With only a rudimentary grasp of siSwati, the communication-gulf separating this Afrikaans doctor from her patients was bridged only with the assistance of nurses who serve as both linguistic and cultural translators.

By labelling African traditional medicine 'primitive' in such a public forum, my initial impressions were that this doctor was little interested in whether her nursing colleagues scattered on surrounding tables might consider this comment inappropriate and somewhat colonial. Upon reflection, it occurred to me that what I had initially considered to be a flippant off-the-cuff remark was instead a calculated declarative position. A polemic aimed squarely at African traditional medicine, and an explicit positioning of her own professional identity.<sup>64</sup>

This courtyard outburst brought into focus the complex realities of fieldwork interaction, particularly the different ways in which hospital staff presented and mediated themselves, their views on medical identity, and their positioning when discussing African traditional medicine. This particular incident aside, I encountered a great deal of expectation that hospital staff should at all times be respectful and understanding, or at the very least outwardly tolerant towards those holding 'other' cultural beliefs. This requirement to embrace and convey the identity of a benevolent, culturally sensitive and respectful medical

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<sup>64</sup> Hall and du Gay (1996) emphasise that identity is constructed within discourse, and within specific historical and institutional formats, and that identity is as much about differential positioning and exclusion, as it is about an affiliation to a constituted group. This young doctor was not only reinforcing her own identity as a biomedical practitioner, but was making an open declaration about how the 'ideal' biomedical practitioners should be positioning themselves in relation to the defined 'other' of African traditional medicine that is prevalent in the area.

professional, is enshrined in the hospital's patient-charter which is prominently displayed throughout the hospital.

Hearing the young doctor label traditional medicine 'primitive' in front of myself, and her colleagues, made me acutely aware of the process of impression management (Goffman, 1959), this with respect to myself as an 'intrusive' researcher<sup>65</sup>, but just as importantly amongst colleagues in a culturally diverse institution.

Sharing the lunch table, and seated opposite, was a Black nurse, a senior manager well known to me through our many informal discussions. In this instance, I was granted a perch from which to observe the series of expressions passing across her face when the young doctor's observation spilled forth into the courtyard. First, a raising of eyebrows conveying a monetary look of surprise, then a slight incline of the head register irritation and indeed anticipation for the explanation we both knew was forthcoming.

This senior nurse's visible irritation was not to be mistaken for an unspoken defence of African traditional medicine. Indeed, I knew her to be a fierce and outspoken critic of *tangoma* and *tinyanga*, and our informal discussions had been peppered with frequent reference to her devout Roman Catholic faith. Like many nurses of a similar disposition, she claimed to view any esoteric practice, apart from eucharistic-transubstantiation of, as satanic dark magic to be avoided at all cost.

I initially suspected, and in a later private discussion confirmed, that her reaction upon hearing indigenous healing described by the doctor as 'primitive', had less to do with the criticism of traditional medicine itself, and more to do with redolent colonial impressions evoked by the label. Impressions arguably magnified because they were uttered by a White-Afrikaner.

As we both sat listening to the doctor elaborating her position, it was clear that she was struggling to conceal a deep well of emotional pain and frustration. She described this frustration as resulting from the a relentlessly confrontation with the deleterious consequences of African traditional medicine in her many years of working in paediatric wards across the country. Her most recent encounter occurred a few days prior to our lunchtime discussion, and served only to reinforce her view that African traditional medicine was 'primitive'.

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<sup>65</sup> In many respects, my presence was clearly disruptive to hospital staff, and the very topic of African traditional medicine and medical pluralism, was sending ripples through the social fabric of Barberton general hospital.



A pause interrupted our midday repast as the senior nurse and I listened to the doctor recount her most recent case. This involved trying to save the life of a HIV-positive six month old child admitted to the paediatric ward with acute dehydration, and with evidence of having been administered excoriating caustic enema. During history-taking, it emerged that the child's mother had knowingly eschewed HIV medication. When her child had recently fallen ill she had sought the help of a sangoma before bringing her to the hospital. As a result of both the dehydrating and excoriating purgative administered by the sangoma, as well as delayed presentation for underlying HIV-related complications, the child was now in a critical condition, and as we were speaking, it was still not clear whether she would survive.<sup>66</sup>

This doctor's most recent case had proved to be disturbing enough to dispel any façade of political correctness and cultural sensitivity that social and institutional convention demanded of her. Instead, she conveyed herself as an authoritative professional holding the knowledge and tools, the epistemic and ontological legitimacy of biomedical culture that she positioned as diametrically opposite to 'primitive' traditional medicine. She employed her physician-status, to articulate her position, and indeed her view of what the position of all those engaged in biomedicine should be, by passing judgment at that moment in time, and in that defined biomedical space.<sup>67</sup>

One might argue that her declared umbrage that innocent unwitting children are subject to 'primitive cultural practices', was leveraged in her attempts to convey an impression of herself as a frustrated, morally-righteous healer. In that moment, much was unveiled about her views on African traditional medicine, and just as much was revealed about the manner in which she mediated and positioned her own professional medical identity relative to a defined 'other', i.e. African traditional medicine, as well as in relation to institutional conventions, structures, and colleagues (Hall and du Gay, 1996).

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<sup>66</sup> The child died later that evening.

<sup>67</sup> These arguments of a 'primitive' African traditional medicine dovetail into wider arguments on the politics of knowledge legitimacy relating to South Africa's indigenous knowledge systems. Ashforth (2005) and Geffen (2010) evoke the political complexities of indigenous knowledge resurgence in post-apartheid South Africa, and in particular, cite one-time physician of President Mandela, Dr Motlana (1988, p17), who conveyed the following to a graduating class of doctors: 'Here at home there are men and women who want to take us back to the dark ages by romanticising the half-naked drummer of the night. They choose to forget that the so-called advanced nations of the west also passed through an age when they believed that diseases were also caused by mists arising from the marshes; they too believed in witchcraft, and it took centuries of turmoil, conflict, of rejecting scientific discoveries to eradicate it.' Dr Motlana is more direct a few paragraphs later where he states: 'One often gets the feeling that some of my comrades in the struggle and in the professions, thrashing around for some meaningful contribution to the total sum of human achievement by Blacks, mistakenly latch onto indigenous medicine as part of that contribution. If so, let us first subject indigenous medicine to rigorous scientific examination before there is the beating of drums in the Great Hall of our University.'

I confess that I found such accounts of the dangerous consequences of African traditional medicine difficult to confront whilst in the field, with many participants in the project bringing to my attention a serious incident that occurred approximately a month before my arrival into phase two. In this case, a child had had her feet amputated because her grandmother had taken her to a 'traditional healer' where treatment had involved suspending the unwitting child over a fire. The resulting gangrenous, suppurating burns had irrevocably altered the child's life-trajectory. To say that staff in the hospital were incensed by these events would be an understatement. Upon realising that the police had been called, and a formal case of neglect lodged, the mother had absconded, her abandoned child placed into a foster home.

In the early weeks of phase two interviews and discussions, it was very difficult to ignore that I too was resonating with the prevailing atmosphere of umbrage projected by many staff as a result of this incident. Whilst speaking to nurses and doctors about traditional medicine, it was usually immediately clear who had heard about this particular case through the institutional grape vine, as many would point to this as evidence of the dangers of 'primitive beliefs', and the horrors visited upon children in particular.

Trying to sort through the morass of this incident was paralysing to say the least. The power dynamic between systems; the life-prospects of the child who, even before the terrible incident had been hampered by her position of birth into poverty; the legitimacy or illegitimacy of the charge of neglect; trying to understand the legal ramifications, and the relationship between State apparatus – Medicine, and the Law – within the plural medical landscape – all these were complex competing issues jockeying for my attention. I soon came to realise that many negative accounts, as described above, resulted in me viewing my fieldwork through a somewhat jaundiced, and perhaps a biased, lens. And these served only to reinforce my admitted predisposition to a Western biomedical paradigm, making it a challenge to approach my work with fair and critical oversight.

After about a month in the facility I found myself in the hospital CEOs office. The matron, a former nurse, immediately sensed my own mild distress, and enquired as to my wellbeing. I explained to her that the nurses and doctors who had agreed to participate in the study, which at that point were few, overwhelmingly cast African traditional medicine into a negative light. Whilst this in itself was not a problem, as all interactions need to be considered in terms of context and positioning, what was concerning was that I could not rid myself of the negative lens through which I was interpreting African traditional medicine. I explained that

I felt this was influencing my interpretation in the field, and, consequently, how I was navigating respondent interviews.

The CEO, an extraordinarily busy, but also extraordinarily intuitive person, encouraged me to cast a more symmetrical gaze in my efforts, and surprisingly, told me to consider the mistakes that happen at the hands of physicians. Mistakes that I would not hear from the biomedical staff themselves. She then spent the next few minutes recounting the story of an incident in 2008, when a three year boy underwent a circumcision at the hands of a Barberton hospital intern. The young boy was sent home, whereupon his mother discovered that, not only the foreskin, but also a significant portion of the glans of his penis had been amputated (Mashile, 2011a, 2011b). Unlike the previous amputation account, no police was called in, and no charge of assault, or battery arose, though it was likely that the intern, and her supervisor, received a reprimand. It appears, that only recently, five years after the event, is the case being taken to court by a constitutional rights lawyer (Oosthuizen, 2013).

I continued with interviews, and with a bit more perspective I could see that nurses and doctors accounts of encounters with African traditional medicine conveyed with significant frustration. Not only because of having to navigate a collision of health practices that challenged their own paradigms, but also because individuals often felt unable to fully articulate their frustrations within the institutional hierarchy of the hospital for fear of upsetting the delicate balance of political and cultural sensitivity.

In short, nobody wanted to formally rock the boat in one of South Africa's model, post-apartheid, 'rainbow-nation' hospitals. My arrival and the topic of my research highlighted the cracks in the (very) thin veneer of plural harmonious co-existence.

Whilst exploring both the perspectives and the positioning of biomedical professionals, I had opened myself to receive the most alarming, and heart-wrenching stories. Tales of pain and death resulting from 'misguided' and 'primitive' beliefs.

One of Barberton's doctors, after having realised he had spent a quarter of an hour lamenting the influence of African traditional medicine on his work, reconsidered his position with the following:

*Of course, we're going to see only the cases that go wrong. This is where they come as a last resort when things **do** go wrong...*

*I've never heard about any success stories that happen in the community, but then I never go into the community. But my concern isn't any success stories, it's what happens in here, and what interferes with what I know will help someone.*

*Dr Pretorius*

It is not a simple matter to ‘map’ the perspectives of a large group of people, as much nuance is lost in the attempt to distil views. Nonetheless, the section that follows is a broad outline of how doctors and nurses positioned themselves with respect to the project topic.

As I went about introducing this study to Barberton general hospital’s senior managers and gatekeepers in the early stages of the project, many communicated their concerns about the challenges I would encounter when recruiting study participants. Doctors, they mused, would most likely be keen participants, however, scheduling a block of interview-time would be challenging due to constraints of heavy clinical workloads. This was, in turn, exacerbated by an acute shortage of doctors within the hospital.

The converse appeared to be the consensus concern for nurse recruitment. Securing interview time was not seen as much of a barrier, instead, the prevailing view was that many nurses might be reluctant to engage in discussions in which African traditional medicine was a primary topic. As one nursing manager elaborated:

*All of them, or maybe eighty or ninety percent [of nurses], take traditional medicines themselves. That is why I think they will probably not want to talk.*

*Nurse Dlamini*

As the project unfolded, I felt the weight of these concerns materialise in the heavy reluctance, and air of weariness, exuded by many nurses, to my interview overtures. The topic of African traditional medicine, combined with the prevailing impression that I was, in some way, an official connected to the Mpumalanga department of health, proved to be a powerful deterrent to participation. However, despite these very real challenges, I did succeed in drawing together nurses and doctors from across the staffing-body.

Two of the eight doctors interviewed disclosed a strong belief in the reality of spiritual or demonic affliction. Of this pair, one was a young White born-again Christian who strongly felt that African traditional healers were incapable of addressing spiritual or demonic affliction, the only recourse being a pastor or Christian healer. The other referred to personal observations from his home country in West Africa where he claims to have witnessed real cases of spiritual affliction and possession, as well as witnessing rituals in which traditional healers cure such afflictions. Despite disclosing this to me, he stresses that this was not

something he had ever spoken about with his fellow doctors due to concerns that they might question his professional integrity and competence.

On the issue concerning the interaction between African traditional medicine and Western biomedicine, and particularly how the former emerges within the hospital, all doctors, without exception, describe African traditional medicine as an unwarranted and unwanted intrusion.

Whilst some doctors shrug their shoulders at the appearance of African traditional medicine within hospital spaces, accepting medical pluralism as part-and-parcel of the challenges of being a doctor in South Africa, others are less tolerant. With only a few exceptions, such as the account in the opening of this chapter, doctors are careful to convey negative views in private and in a politically sensitive manner.

Eight of the twenty-eight nurses were open about their personal use of traditional medicine, whilst five nurses avoided expressing any personal views on the matter. These five projected an air of disinterest, and indeed ignorance, and it was evident that they found the topic sensitive. However, as the project evolved, I would learn that this air of projected ignorance and indifference was largely feigned, as later informal discussions would indicate that some of these nurses were far more knowledgeable than they initially claimed. Some who would later engage in more informal discussions, explained their initial reticence arose from suspicious of my motives in asking questions about African traditional medicine.

More than half of the nurse participants (fifteen) were very quick to invoke their Christian faith early on during interviews and, with a few exceptions, this seemed largely to leverage their faith as a means of positioning themselves as opposed to traditional healers, and many rolled out what was to become a frequently encountered phrase *'I was raised in a Christian home'*. More than a statement of fact, this served to declare that they had no interest in African traditional medicine, and that they have had little proximity thereto. However this is not to say that none of them engage in any form of religious and prophetic healing practiced within the boundaries of the charismatic Zionist Christian sects. Indeed one senior paediatric nurse claimed to resort exclusively to faith healing when she got ill.

*Even when I get a headache, I don't even take one Disprin or Panado [aspirin]. I only pray.*

*Nurse Khumalo*

The evocation of Christian faith as a means of positioning oneself against African traditional healing while common, was not universal. Nurse Dlamini, a senior manager who unlike many colleagues was not reticent when it came to voicing her views, identified herself as a devout Christian, as well as an unapologetic user of traditional medicine. Unapologetic because she describes herself as being looked down upon by many in her congregation for using traditional medicines.

Emerging as someone who I could rely on to expand on, and explore, unfamiliar Swazi terminology and concepts encountered during my discussions and interviews, she made a particular point of urging me to view any staunch refusal of African traditional medicine by nurses, on the grounds of their Christian affiliations, with guarded suspicion. At the same time, she delivered a vociferous condemnation of local pastors, priests, and prophets, frequently branding them hypocrites.

*I'm a Christian, but I also do believe that traditional medicines can be helpful.... These [systems] are not incompatible.*

*[If] You go out in the community, you'll hear this pastor and that one say that it's wrong to go to the sangoma, that it's against the bible. These are the biggest hypocrites. They'll say don't go to the sangoma, but in the dark, when they think no one sees, **they** go to the sangoma.*

*It's the same with the nurses, they will say to you, I am Christian, the bible says this A, B, C, what-what-what [slang: etcetera], so I don't use those things [traditional healers / medicines]. But many you can be sure, are not telling the truth.*

*Nurse Dlamini*

### **5.3 Hospital encounters with African traditional medicine**

Dr Venter's private surgery resides in what was once a Whites-only suburb, occupying a veranda-wrapped colonial-era house. In halting and broken English, the Afrikaans receptionist, curious at my entry and request to speak to the doctor about my proposed research, directed me to an empty unlit waiting room, where I could peruse well-thumbed magazines of affluent middle-class concerns - golf, sailing, and luxury cars – in air-conditioned comfort, while the doctor finished his lunch.

Dr Venter was in his late forties and spoke English with a heavy Afrikaans accent. Currently running a private family practice, he previously held positions in the government sector as a Public Health officer, and prior to that, he was medical manager for a large public hospital in

Mpumalanga province. With more than two decades spent working in various clinical positions in the public sector, he claims to have frequently encountered African traditional medicine, and is quite candid about his negative and dismissive views thereof.

*The people that come here [to my private practice], they are educated. They don't use that stuff [traditional medicine]. I had to deal with it in the hospitals, but my patients here are educated.*

*Dr Venter*

That those patients attending his private practice were educated was a frequent refrain during our discussion. African traditional medicine was described as a significant impediment to doctors who have to “*clean up the mess of sangomas and witchdoctors*”.

While those using traditional medicines are labelled uneducated, those practising and dispensing traditional medicine are either described as misguided, or viewed as opportunistic charlatans, preying on the ignorant and uneducated under the pretext of tradition and culture. African traditional medicine is, in Dr Venter's view, an avenue for, and of, the ignorant who remain shackled by superstition.

Perhaps concerned that his views might be misconstrued as racial prejudice, he further clarified his position with: ‘Look, its got nothing to do with Black and White you know. I get Black patients here too, but they are educated. They wouldn't use that stuff.’

In Dr Venter's view, those who resort to traditional healers were to be pitied for their ignorance, and if possible, educated as to the error of their ways. Dr Venter's positioned himself in his account as a professional who had served his time in the trenches. He was now spending the ‘golden’ years of his medical career, dealing with patients who were ‘*less complicated*’. Patients who did not challenge his biomedical expertise, who followed his directives, and patients with whom he has a far easier time communicating, both culturally and linguistically.

My meeting with Dr Venter occurred early in phase two, whilst I was awaiting permission from the local government to commence my study within Barberton's public institutions. While it was clear that he had little interest in engaging in any substantive discussion about African traditional medicine, beyond declaring it the avenue of the ignorant, he was nonetheless helpful in making suggestions on where in the local hospital I might best focus my attentions. Areas where, he was certain, I would encounter significant therapeutic overlap between African traditional medicine and Western biomedicine. “Look, don't take

my word for it” were his parting words as I shuffled out of his air-conditioned office. “Just go speak to the nurses and doctors in the paediatric and maternity wards.”

A significant component of my respondent interview schedule was designed to explore where, and how, traditional medicine is said to be encountered by nurses and doctors in Barberton general hospital. This aspect of the interview schedule evolved within the early stages of access negotiation where informants would often direct my attention to areas of interest, such as the hospital’s maternity and paediatric wards, where traditional medicine is said to be a frequent encountered problem. And as I began exploring accounts of doctors’ and nurses’ encounters with African traditional medicine within the hospital, a loose typology started emerging based on circumstance and context. This emergent typology can, to some extent, be grouped by where in the order of treatment-seeking by patients, doctors and nurses think, or know, that Western medicine has been placed. These ‘types’ of encounters can be grouped as follows:

- **Traditional medicine as pathology:** Encounters with patients as a direct or indirect consequence of African traditional medicine use. This also includes delayed presentation to a biomedical facility.
- **Biomedical treatment interruption:** Encounters with patients suspending biomedical treatment to seek alternative treatment from a traditional healer.
- **Multiple concurrent treatment:** Patients wishing to consume traditional medicines alongside biomedical therapy whilst in the hospital.

Before launching into a more detailed account of the above categories, it should be emphasised that they refer only to described encounters with traditional medicine through interactions with patients in hospital spaces.

Furthermore, it should also be noted that these are largely couched and conveyed in a negative context, leaving one with the impression that African traditional medicine is an unwanted intrusion into a biomedical sphere. Even nurses who disclosed a personal use of indigenous healing claimed to be in favour of keeping the internal boundaries of the hospital free from the influence of ‘other’ therapeutic systems. ‘Mixing’, as the concomitant use of more than one therapeutic intervention is referred to by nurses, is heavily frowned upon by



all.<sup>68</sup> A second aspect to note, is that these are not entirely discrete categories, but, nonetheless, heuristically useful.

### 5.3.1 *Traditional medicine as pathology*

*Encounters with patients as a direct or indirect consequence of African traditional medicine, including delayed presentation to a biomedical facility.*

This category deals primarily with instances in which patients are suspected, or confirmed, to have consulted an African traditional healer prior to coming to hospital, and where hospital treatment is necessitated, either partially or entirely, as a consequence of this visit. I refer to this category as *traditional medicine as pathology* because African traditional medicine, *muti* or *imbita*, is often directly implicated in either the primary diagnosis, or, at the very least, considered within the differential diagnoses.

Adverse consequences resulting from traditional medicine use are said to be reflected in a number of symptoms including: hepatic failure; metabolic acidosis; vomiting of a ‘suspect’ substance<sup>69</sup>; acute dehydration; scarification<sup>70</sup>; acute abdominal distensions; burns - including chemical burns; evidence of the use of purgatives and emetics; and, unique to the obstetrics and maternity ward, sudden onset of acute, often described as violent, uterine contractions.

Some of these symptoms - for example evidence of scarification, the use of purgatives and emetics, and early-onset labour with no, or minimal cervical dilation - are considered to be a clear indication of potentially harmful African traditional medicine use. However, symptoms such as hepatic and renal failure are often associated with other diseases such as HIV, and thus African traditional medicine is a suspect amongst a range of differential diagnoses.

If traditional medicine use is suspected, doctors and nurses claim to question patients or their guardians, about the timeframe of illness onset, and what other therapeutic avenues were sought prior to the hospital visitation. Doctors, few of who speak passing siSwati, describe

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68 These views are also reflected in Sumaya Mall’s (2005) work exploring nursing perception of African traditional medicine in Cape Town. Mall, however, does little to consider participant positioning, exploring how or why nurses might be espousing a position.

69 Usually described as a foul smelling dark-green, black, or brown liquid.

70 These are colloquially referred to as *eleveneses*, the name describing the two parallel razor-incisions resembling the number eleven. Interestingly, no doctors knew that ‘*eleveneses*’ was local terminology for scarification. All nurses encountered knew this term.

relying entirely on nurses as translators, when enquiring if any ‘other medicines’ were taken. The indirect reference to ‘other medicines’ does not directly implicate African traditional medicine, though doctors use this open ended question to try and appear non-accusatory or non-judgmental, while apparently allowing for an open space for patients to respond.

Various scenarios are presented by doctors and nurses under this category. First, is the assumption that an individual may have had no initial underlying ‘bio-physical’, that is a ‘real’<sup>71</sup> disease, and admission to hospital is solely the result of the complications raised by being treated by a traditional healer. Also, there may well be an underlying illness, and upon recognition, patients pursue traditional healing first. Delayed presentation to the hospital is then assumed to lead to an exacerbation of the problem.

Common examples under this category include the application of engine oil, ash, cow-dung, or other unknown substances onto the umbilical stumps of new born children; burns suffered by patients undergoing treatment that involved some application of heat or excoriating chemical such as bleach; and probably the most frequent scenario, acute dehydration resulting from a purgative or emetic, usually said to be particularly problematic in children.

In this respect, doctors and nurses alike express concern that patients are delaying presentation to the hospital for what might potentially be a serious problem. Even when a patient’s exposure to traditional medicine is known, doctors and nurses remain largely ignorant as to whether these interventions are benign or harmful. If the latter, this potentially adds to the constellation of symptoms on presentation to a hospital.

From doctors in particular, accounts of African traditional medicines in this regard were couched in terms of the ‘noise’ it creates for biomedical practitioners. Traditional medicines muddy the waters, so to speak, and clinicians describe having to unravel multiple presenting symptoms, some of which may point to an underlying ‘real’ problem, and some of which may be associated with traditional medicines. Even the nurse respondents who admitted to regular personal use of traditional medicine, were vocal about their concerns relating to the delay of patients coming to hospital for illnesses that, as far as they were concerned, fall squarely within the biomedical domain. It is also these nurses who advocate that traditional healers should be taught to recognise and differentiate between ‘African’ illnesses and ‘Biomedical’ illnesses.

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71 ‘Real’ as defined by biomedical practitioners.

### 5.3.2 *Biomedical treatment interruption:*

*Encounters with patients suspending biomedical treatment to seek alternative treatment from a traditional healer.*

This category refers to instances in which patients who, following presentation and admission to hospital, subsequently attempt to suspend biomedical treatment in favour of seeking help from a traditional healer.

This curtailment warrants a procedure where the patient is required to sign a refusal of hospital treatment form, the form widely referred to by its acronym RHT. This form absolves the hospital and its practitioners of responsibility by clearly stating that the named patient: (I) is discharging him or herself against medical advice, (II) acknowledges that they have had the risks explained, and (III) fully understands the risks associated with early discharge and incomplete treatment.

Patients are frequently characterised as being somewhat obscure and secretive about their reasons for wanting to self-discharge, and a number of euphemisms have emerged, which indicate to nurses and doctors that a patient means to seek help from an African traditional healer. These include patients *wanting to go to another place to get help*; or *wanting to go to another doctor who is not in the hospital*, and so on. Often, no explicit mention of a *sangoma*, or a traditional healer is made. Nurses suggest that by doing so, they risk drawing criticism from doctors and nurses, however, all parties in the discussion are aware of these euphemisms, and their meanings.

*When a patients says, ya, I want to discharge, usually they say to go somewhere else. What they really mean is they want to go to a sangoma. Very few say ya, I want to go to the traditional healer.*

*Nurse Simelane*

It was often said, by nurses and doctors, that some patients have very little say in the choice of therapy, and instead are entirely at the mercy of decisions made by parents and family members. In this, participants evoke Janzen's observations on the wider therapeutic management group (Janzen, 1995).

Nurses are, in effect, linguistic translators between doctors and patients, and are then key figures in what is described as a negotiation process to try and persuade patients, and their

therapeutic management groups, not to cease treatment. One of the chief challenges raised by nurses and doctors in this regard is trying to persuade patients that biomedical treatment can be a complex undertaking.

*If the patient doesn't get better rapidly, it doesn't matter how much I explain. Families start feeling nothing's being done. And as soon as I leave the room they start asking nurses for an RHT.*

*Of course it depends on the circumstances. If a patient has just had an emergency op, there's not much chance they'll get up and leave. But if it's a medical case [i.e. not a surgical case] and we have to try several courses of treatment because they are not responding, then families start thinking that they've made a mistake in bringing the patient to the hospital, and then they sign an RHT and remove the patient before we've gotten to the bottom of things.*

*Dr Van Niekerk*

*I have patients that sign RHTs, and when they go, I know they will be back in a few days, maybe a week. Either that, or they'll be dead. And when they come back, then they beg for help again. And sometimes the families don't agree even then, and you can see they [the families] don't want the patient to be here. They then get angry and threaten us, saying that if the patient dies, it's my fault, and they're going to sue me! Meanwhile it's them that took the patient out [from the hospital] in the first place!*

*Nurse Dierkse*

Reported instances of biomedical treatment interruption seem to be confined to the medical wards within the hospital. Whilst there have been occurrences of parents and guardians attempting to suspend their child's treatment, doctors have the capacity to override decisions that, in their professional opinion, might conflict with the child's best interests and welfare.

### 5.3.3 Multiple concurrent therapy

*Encounters with patients consuming traditional medicine alongside biomedical therapy whilst in the hospital.*

That traditional medicines are smuggled in, concealed, and clandestinely consumed within hospital spaces, is widely acknowledged, and this *mixing* is almost universally criticised by doctors and nurses. *Mixing* is the term used by nurses to describe patients who attempt to take both African traditional medicine and Western biomedicine simultaneously, and, like the previous category, the therapeutic management group is heavily implicated since the patient is reliant entirely on family to ‘smuggle’ traditional medicines into the biomedical space.

There is a general dissatisfaction with patients who attempt to conceal and consume traditional medicines within the hospital spaces for a number of reasons. The potential for any active ingredient in the *imbita* to interfere with western biomedical ministrations is usually the first and foremost concern raised by participants. In particular, doctors suspect that traditional ‘herbal’ remedies may interfere with the patient’s metabolism, this in turn supposedly interfering with uptake and efficacy of any biomedical intervention. But threaded through these discussions, and related to them, is a widespread dissatisfaction with the extra ‘noise’ associated with African traditional medicine, that is, the added layer of complexity that might be introduced by the patient’s consumption of traditional medicines. By this, doctors refer to both aspects of physiology, i.e. biological ‘noise’ that interferes with their primary work on the patient-body, but also behavioural ‘noise’ – in which the patients actions, and indeed their families actions, choices, and credibility are placed under scrutiny.

*The patient was initially responding very well to treatment. But after two – three days, he started looking ill again, a complete reversal. And the doctor was just confused - saying this isn’t right. But I suspected he [the patient] was mixing. I asked him if he was mixing, and he denied. But these patients... [shakes her head] you have to watch.*

*The day after, I was working in the room when the family came in, and they drew the curtains around the bed, and then I knew that something is going on. It turns out the family was giving him imbata – its like this brown liquid with all the herbs and medicines, in a coke-bottle. Normally, they leave it [the imbata], they hide it here in the hospital, but people now know that if we find it, we confiscate it. So the family were bringing it in every day, and taking it out again.<sup>72</sup>*

Nurse Magobeni

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<sup>72</sup> I further enquired as to how she discovered the patient was consuming *imbata*. It turns out that this had been brought to her attention by the family themselves, but only following her intervention, which included a lengthy explanation of the patient’s rapidly deteriorating state, and her suspicions that this was a direct result of his consumption of *imbata*.

Nurses, including self-confessed users of traditional medicines, predominantly argue for non-concurrent treatment. In this respect the argument runs that patients are free to use whatever therapeutic avenue they feel necessary, and the nurses job is not to dissuade patients from a particular decision.

*There shouldn't be mixing, because we haven't tested to see the cross-effects of our medications with imbita. Patients' choices must be respected, but at the same time, if I am not giving the patients all the information they need to make decisions, then I am also at fault. So when confronted with a patient who is mixing, I will give them the best information I have. I will say, they should take either traditional, or biomedicine, and see which one works. And if one doesn't, then you know maybe you should choose another route. But I will say, let us try ours first, without mixing. Give us a chance, and if we cannot help, then go see a sangoma, because then maybe its an illness we cannot cure. But please try ours first.*

*Nurse Dlamini*

Indeed, an extension of this argument is that the consecutive use of different therapies can act as a useful diagnostic tool for the patient. A process of diagnostic elimination so to speak.<sup>73</sup>

Whilst I consider the above typology to be a rough outline, a representation of how nurses and doctors claim to confront African traditional medicine within the facility, it is admittedly a very specific and narrow view of African traditional medicine from a clinical and public health perspective.

The above is also a very crude attempt at categorising biomedical professionals encounters with African traditional medicine. It should however be kept in mind that doctors claimed to have no interaction with local traditional healers. Indeed most of the doctors interviewed were not even aware that two of the nursing staff were practicing *sangomas*. In contrast, all nurses spoken to, were fully aware of this.

Whilst this simple typology paints an introductory picture of sorts, these of course emerge from accounts within the hospital, and in particular, revolve around participants' experiences and observations, and encounters with traditional medicines as they emerge in specific areas of the facility. The most prominent areas of interest, or I should rather say areas of impact, are said to be maternity and paediatric wards.

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73 This utilising of different therapeutic avenues as a diagnostic tool, has also been raised by Langwick (2008).

## 5.4 *Sites of concern*

### 5.4.1 *The paediatric ward*

My first respondent-interview at Barberton General Hospital was held with Nurse Khoza, in a crumbling and dusty classroom-cum-office housed in the teaching block where she taught. The more formal element of the interview was completed in around forty minutes, after which she offered to show me around the facility, where our discussion continued in a more informal, and narrative in manner.

Her views, as conveyed in the office, evidenced a clear disapproval of African traditional medicine, though not in the overly critical. Rather, her views painted a portrait of herself as pitying those who use, and believe in, African traditional medicine, and her views were laden with an unmistakable Christian-flavour, and animated with the occasional offhand and somewhat patronising gesticulations aimed in the direction of Emjindini tribal trust, coupled with an oblique reference to ‘...*those Blacks over there believe in those things...*’.

I confess that the observation, delivered in the manner that it was, surprised me somewhat, and piqued my interest. This reference to ‘... *those Blacks over there...*’ was clearly a statement of positioning, that, in this instance, had as much to do with her fundamental religious affiliations, intertwined with her role as a senior nursing educator. She was not, as is the obvious implication, one of those ‘*Blacks over there*’. And indeed Nurse Khoza’s was not the only person to make such a reference, as only two days later, I would be faced with an almost identical observation from one of nurse Khoza’s lecturer colleagues, who also nodded in the direction of Emjindini tribal trust declaring “... *those Blacks are uneducated...*”. As I left the lecture room on that day, I ruminated on how Dr Venter, who declared the patrons of his private practice as educated, would thoroughly approve of the observations of these two educationalists.

Nurse Khoza had clearly endorsed my project during our respondent interview, though I did get the impression that she interpreted my project as one in which I was not merely exploring the realities of medical pluralism, but rather exploring the misguided beliefs of those who believe in African traditional medicine, and how the hospital tries to manage such ‘beliefs’.

She also made it clear that she was interested in how staff, particularly the Black nursing staff, might respond to me and the project topic, pointing out several times that I might have difficulty in getting nurses to engage with me in any substantive discussion on African

traditional medicine. And this was perhaps one of the reasons she took it upon herself, during our wander around the facility, to prime me to the upcoming task by occasionally stopping at places where she thought I ought to spend time exploring.

We passed and paused by wards, offices, and doors with names of managers she suggested I approach. When she felt that a particular point needed to be definitively driven through, she would stop and lean over to me, and in a conspiratorially whisper, which to observers must surely have looked suspicious. *“There are two sangoma who work in this ward...” “Last month I think, the social worker had to be called to deal with a mother who neglected her child by not bringing him here. She took him to the sangoma instead... the police had to be called in” “See those cabinets next to patients. There will be imbita hidden in some of them.” “Imbita, its just another name for muti. But only the traditional healer knows what is in it. The patients don’t know what they are taking.” “You mentioned the sangoma initiation ceremony. That manager [pointing to an office] will know, because I think her sister is a sangoma.”*

We eventually wound our way down a long dusty and leaf-strewn corridor to an annex located in the north-east corner of the facility. She drew me in past the staff desk around which were seated five nurses of various grades. Children were lying in the surrounding beds, and mothers and grandmothers were either sitting on chairs, or reclining on pieces of old foam mattress placed on the ground beside their sick children.

After the briefest of greetings to the seated, and clearly inquisitive, nurses, Nurse Khoza drew me into the centre of the room, so that I could get a better visual perspective of the ward. The seated nurses, however, were clearly not ignoring us, and they looked at us quizzically. Nurse Khoza proceeded to tell me of how the paediatric ward was the place of most significant concern when it came to issues of African traditional medicine. *“Distended abdomens, herbal intoxication, diarrhoea cause by imbita. We often see it in here.”* Indeed, without exception, almost all participants in the study drew my attention to the paediatric ward as a site of particular concern. Doctors in particular, find their encounters in the paediatric ward challenging.

*I’ve often seen patients die directly as a result of traditional medicine, for example children who come in with diarrhoea, electrolyte disturbances, metabolic acidosis, and then they die because of a specific traditional intervention.*

*Dr Jansen Van Rensburg*



*Well, I can actually tell you about two in the last week. One was a baby who came back six days after being born. He was sick with septic shock. The history was that the traditional healer put cow dung on the umbilical stump. I don't know why. But, the baby was severely ill.*

*Another child we saw, had all of these ropes around him, also around the neck, and that child there was chafing. And it looked like this child was being strangled, but obviously it was because of those things [ropes]. I think their methods is harsh. Harsh and primitive, in some cases, like **really** primitive.<sup>74</sup>*

*Dr Van Niekerk*

*The bigger problems come with the paediatric side. We often end up having full resuscitates on kiddies, children who end up passing away who have significant co-morbidities as a result of traditional medicine.*

*Dr Smythe*

From topical 'muti' applications that lead to infections, burns and scalding from the use of heat or caustic chemicals, and the use of emetics and purgatives – the array of adverse effects on children resulting from what are considered 'traditional' medicines, is said to be wide and varied. Accounts of African traditional medicine involving children mainly fall under the category of *African traditional medicine as pathology*. And whilst scarification, the topical application of muti, and scalds and burns are cited as common occurrences, it is the 'hidden' traditional interventions that are most frequently brought up in doctors' and nurses' narratives and accounts. By which I mean interventions whose effects are not always visible, such as purgatives, emetics, and ingested 'herbal remedies'.

Where there is confirmation, usually by a guardian or parent, that a child has ingested something from a traditional healer, and where this is thought to be causing or contributing to illness, it is officially recorded in patient notes as *herbal intoxication*. Apart from this medicalised term, no other reference to traditional medicine is recorded. In effect, *herbal intoxication* has become the official biomedical-handle for the ingestions of any traditional medicine considered to have resulted in an adverse reaction.

The lack of information on ingredients used in 'traditional' decoctions and concoctions is a major criticism viewed by all doctors and most nurses. All biomedical professionals are cognizant of how guarded traditional healers are of these medicines, such that even the patients themselves, and their parents and guardians, are unaware of what is consumed.

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74 This being the second reference by a doctor, to traditional medicine being primitive.

*Not even patients know what's in this muti<sup>75</sup>, so even when they do come forward, which isn't often, and say 'I gave my child this stuff', it means very little. So now the parents are worried sick, and they're saying it's our job to save their child, and all we've got to work with are symptoms.<sup>76</sup>*

*Dr Habashane*

The label of *herbal intoxication*, though appearing on official patient records, essentially serves as a label of ambiguity, and one which, I would suggest, also serves as much to illuminate patient choice and behaviour, or rather the choices made for them by parents and their wider therapeutic management group.

It was frequently suggested that a child, by nature of their delicate constitution, and limited capacity to deal with shocks to the body, were more vulnerable to the potential toxicities of herbal medications than adults. Doctors' concerns regarding the risks of toxicity from African traditional medicine in children are not insignificant. Distended abdomens, hepatic and or renal failure, severe dehydration, metabolic acidosis, are all thought to be significant markers of 'herbal toxicity'.

The primary antagonism towards the use of African traditional medicine on children arose from the perception that both healers and parents were breaching a moral ethical boundary in this regard. Children, as doctors largely convey, are unwittingly subjected to potentially harmful and untested 'traditional' remedies. Remedies that nurses, who are more familiar with African traditional medicine, highlight as having no standardised dosage and have not been tested for potential toxicities. Doctors refer to children as being hapless, and helpless victims of circumstance and ignorance, at the mercy of dangerous 'beliefs'.

As one doctor put it to me when describing a case of a child who had been left severely dehydrated and in a critical condition after being subjected to an enema: "*In **any** other circumstance, this would without a doubt be child abuse. But here, we call it culture...*" she said shaking her head.

The overt implications in the various discussions I was having with doctors, was that I should, in the course of my study, turn my analytical eye onto exploring the ethical

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75 Doctors are far more accustomed to using the term muti, whilst nurses, particularly those who are from the local area, usually use imbita. These are interchangeable.

76 As with all discussions, multiple layers frequently emerge. Included in the wider discussion in which the above was said, was the doctor's dissatisfaction with the oft-cited charge that those in his profession treat symptoms, rather than address the route of illness and disease. Doctors also express dissatisfaction with patients who make poor treatment choices for their children, and then expect, and apparently sometimes threaten biomedical professionals, as to any harm that might befalls their child. "*The mother was frantic, and actually threatened me if anything bad happened to her child. In the mean-time, I'm busy trying to stabilise the child, and when I get to pumping its stomach this black-stuff out of the child's stomach.*" Dr Pretorius.

dimensions of African traditional medicine itself, which is considered by the majority of doctors to be either inadequate or absent. The implicit argument of course being that a comparison should, and could, be made with Western biomedical ethical principles.<sup>77</sup>

*If you're an adult and you want to take traditional medicines, do whatever the hell you want, but these kids that come in, they don't have a choice. And I'll be honest, I get so angry with the parents, but I shouldn't because they don't know better.*

*Dr Jansen Van Rensburg*

*You know there's this kid that came in the other day with his whole back-end raw with severe burns. And we found out what happened, and you know what, this poor kiddie got a Jik [bleach] enema. It's not the first time, and it won't be the last, but we can sit and ask, was he a real healer, or was he a charlatan? But then how are people supposed to tell? Seriously? What are we supposed to think about a "healer" [gesticulates] that thinks a Jik enema is in any way okay?*

*And when we ask the parents - well the mother, because it's usually just the mother there - and they say oh it's the "healers" fault, but how do we know that's just not an excuse to pass the blame?*

*Dr Smythe*

The widespread use, and consequences, of purgatives, emetics and enemas was well known to Dr Swart, a locum doctor who had been practicing in public hospitals in and around South Africa for more than fifteen years. Unlike the other doctors interviewed, he describes undertaking home visits within various townships in the adjoining province of KwaZulu Natal, and engaging with healers to try and understand certain 'traditional' interventions. This, he puts forward, is because many of the 'traditional' interventions he was encountering in paediatric wards, specifically the use of bleach and engine oil, erode any credibility to the oft-stated claims that African traditional medicine is 'natural'.

Indeed, five doctors and nine nurses raised concerns that bleach was being used in enemas challenging the notion that African traditional medicine was 'natural'.<sup>78</sup> Only Dr Swart pointed out parallels between cultural notions of dirt and pollution, and why a well known disinfectant might be used to as a cleaning agent.

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<sup>77</sup> See Nyika (2009) and Nyika (2007), as well as Willcox and Bodeker (2010)

<sup>78</sup> The use of Jik on the body, has also been implicated in other areas. Karim et al (1995) uncovered the use of Jik enemas in douches to precipitate 'dry-sex'.

*We get a lot of kids with diarrhoea. And from what I understand, diarrhoea is seen as something unhygienic. What I mean is I think it's not seen as a symptom, but a cause, and that the person needs to be cleaned out.*

*Dr Swart,*

The widespread use of bleach in matters of hygiene is certainly not unusual in South Africa. Particularly where governments sanction its use, albeit in highly diluted amounts, to purify drinking water and combat cholera (Gabashane, 2009).

As I navigated my way through one interview after the next, it was evident that participants had different ideas about who was responsible for instances where children were harmed as a result of 'exposure' to African traditional medicine. Four of the eight doctors blamed traditional healers outright, although they would also later convey the complications of attempting to apportion blame on a practice with ill-defined boundaries, fully cognizant that traditional healers are not a homogenous group.

Generally, nurses, particularly those who appeared to be sitting on the fence with regards to the efficacy and use of traditional medicines, were far more inclined to identify parents as being responsible in their child's malady.

A line of argument emerging from a small group of nurses was that parents clearly did not fully understand the instructions of traditional healers with regards to administering *imbiba*, and that overzealous parents would often ply their children with a greater than stipulated dose of the traditional medicine.

*Parents think that if you give the child maybe a bit more, it will work stronger. So should I be blaming the traditional healer?*

*Nurse Mahlalela*

*Yes its natural<sup>79</sup>, but it still needs to be given as directed. If the healer says take half a cup, then you mustn't take two-three [cups]. They [the parent] think stronger is better, and will help the child get better quicker. That happens with our [pharmaceutical] medicines as well, which means it's really to do with the parents.*

*Nurse Tshabalala*

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<sup>79</sup> In this instance, the nurse had already staked out a position, describing traditional medicines being comprised of only 'natural' ingredients. Traditional medicine is often described as being 'closer' to nature, uncorrupted by the refining and packaging of 'modern' synthetic Western medicine.

*I don't think it's the fault of the healer. I think it's the parents who don't follow the healer's directions.*

*Nurse Gabashane*

Interestingly, nurses who condemned parents for being at fault in 'mis-administering' traditional medicines to children, also join their colleagues in criticising African traditional medicine for being poorly regulated, with little testing of medicines, and little standardisation of treatments.

A few practitioners also referred to current political realities where, in a post-apartheid South Africa, they feel that traditional medicine has attained a level of status and legitimacy, which is difficult to openly challenge .

*Sometimes I think it's more important for people to be politically correct, and to not offend someone because of their beliefs, than to point out that those very beliefs are responsible for the hurting children.*

*Dr Janse van Resnburg*

With regards to how some doctors manage instances in which traditional medicine is thought to have compromised the health of a child, it would appear that there are some within that have developed long standing reputations for being combative.

*You know I have to tell you, we have screamers as well... doctors, they scream... I figure it's a way of getting rid of the frustration. One of the screamers is our best doctor in the children's ward. She screams and that makes it uncomfortable for us [nurses] and for the patients' parents. And yet she'll scream, and then she'll start saving the baby's life. There'll be a huge effort to save the baby's life. So in the end its very positive, And in the end you'll find out that the relatives actually act positive towards that, because the emotional outburst shown by the doctor... the patient's [parents]... sees that the doctor is really trying to help the child.*

*Nurse Venter*

A few doctors conceded that their negative views and attitudes result from limited knowledge, with some doctors also recognising that their professional field made it difficult to view African traditional medicine in anything but a negative context.

*Look, I'm sceptical definitely, but then I do understand that I only see the complications and the worst case scenarios from complications. But I mean they [the complications] are bad. People die from it.*

*We see lots of bad things they are given to drink and then they [the children] go into liver failure and we have no idea what has been given. If you had been here a few weeks ago, maybe you could have asked a patient some of these questions. We had this poor child who had been given a Jik [bleach] enema. People might think of traditional medicines using herbs, and tree bark, and throwing bones, but come on! I mean Jik!*

*Dr Pretorius*

It is difficult to find a balance when describing views of biomedical professionals on the use of African traditional medicine in children. And indeed, I would, in many instances, encounter nurses who found this subject upsetting. Nurse Dierkse, in particular, had initially agreed to talk to me, but over several weeks, had cancelled appointments several times. When we did come to have our discussion it was evident that the subject of African traditional medicine was sensitive.

*It makes me so cross. I mean we're living in a civilised world. I'm not saying they're not civilised, but we're living in a civilised world, we're moving forwards. If you see the children, the little ones that come in with herbal intoxication and then die, they drank so much imbitas. And what is the doctor going to do with them? And then you find out the child has been sick for two weeks, and the mother has been going to the inyanga every day to get medicine, and now the child is nearly dead. Hardly breathing. and now she comes to the hospital. And now what must we do with the baby? Tell me? What must you do? It's going to die, there's nothing I can do.*

*Nurse Dierkse*

There is an air of frustration and abject defeat when nurse Dierkse talks about her own encounters with children who are thought to have been harmed by African traditional medicine. A good deal of her frustrations arise from her perceived helplessness of the situation explaining that there is nothing one can say to challenge African traditional medicine use in the hospital. There is no forum through which she could vent her anger or discuss her frustrations. Indeed, these strictures nurse Dierkse talks about were raised by a number of hospital staff.

#### 5.4.2 *The maternity ward*

*“It’s like pitosin, but herbal. Natural, but much much stronger”* said nurse Masango. Unlike many other participants, nurse Masango did not try and ‘feel-out’ my own views on African traditional medicine, but instead launched into responding to questions directly, drawing constantly from her nursing knowledge, observations, and experience.

Nurse Masango identified herself as a professional, explicitly differentiating herself from the surrounding staff nurses by virtue of her longer, and more demanding training. She claimed to no longer personally use African traditional medicine:

*Of course I used to use traditional medicines when I was growing-up. When you are a child you don’t have a choice, and you just do what parents say. But when I was older, and I had become a nurse, I made a decision that traditional medicine was not for me.*

Nurse Masango

Despite this, nurse Masango, like many of Barberton’s nurses, was still in close proximity to African traditional medicine, as her sister was a *sangoma*. Interestingly, she went on to explain how her sister often came to her seeking advice about some of her cases.

The dominant thread of our discussion revolved around her experiences of working in the maternity ward, and it was she who first brought to my attention the traditional child birthing intervention known as *masheshisa*. The term, she explains, stems from the Swazi root word, *shesa* – meaning quick or fast. It is also widely referred to in the hospital as *isihlambezo*, from the Zulu verb *uku-hlambeza*: to wash ceremonially, or purify. These interchangeable terms were also referred to by nurses as herbal-pitosin.

*“Pitosin?”* I asked? A term which I would later find out was the trade name for synthetic oxytocin. *“I’m sorry, I keep forgetting you’re not a medic.”* she replied with a good-natured smile before explaining that pitosin, or rather oxytocin, is used to induce uterine contractions.

*“So when you say its herbal and natural...”* I ventured, wondering whether there was a deeper context to her use of these words. A number of nurses I had already interviewed had used the term natural to differentiate African traditional medicine from Western biomedicine – i.e. by implying that proximity to ‘nature’ of the former was sometimes preferable to the synthetic qualities of the latter.

She immediately picked up on the implication in my question. “I don’t mean natural as in it’s good or bad. Like some say they prefer traditional medicines to biomedicines because they think its natural, as if it’s better. No, I mean natural just because its naturally occurring.”

If the paediatric ward emerged as the department most frequently referenced where discussions on encounters with traditional medicine were concerned, a close second contender would be the maternity ward, with its frequent cases of *masheshisa* or *isihlambezo* induced labour .

Before discussion this, however, I do want to identify that here appears to be a discrepancy in how these two words are interchangeably used, as while they are referred to as the self same traditional remedy, they have very different root connotations, one referring to a cleansing, the other to a speeding up of labour. In the existing literature, Varga and Veal (1997), and Veale et al (Veale et al., 1992), refer to *isihlambezo* as an ante-natal remedy taken some months leading up to labour. A very different remedy from *masheshisa* which is taken at the point of labour, and which leads to uterine contractions, and often a precipitate labour. However, in other literature, *isihlambezo* is referred to in the same manner as *masheshisa*, i.e. as an oxytocic uterotonic (see Morris and Mdlalose, 2012).

A ‘Zulu’ remedy that is perhaps far more comparative to *masheshisa* would likely be the herbal interventions referred to as *inembe*, and *imbelekisane*, both of which are described as highly potent, and potentially dangerous, labour inducers, (see Varga and Veale, 1997, Veal et al, 1992). Significantly, these are also considered ‘traditional’ abortefactants.

In my own study, the terms are used interchangeably by Barberton’s nurses who refer to it as an oxytocic uterotonic. Biomedical professionals are keen to point to this specific traditional birthing remedy as being potentially dangerous, as it is usually implicated at the point of labour.<sup>80</sup> When taken in incorrect dose, at the incorrect time, it is said to lead to a precipitate-labour or precipitate delivery - the rapid expulsion of the child without giving enough time for tissues to stretch and accommodate rapid descent.

Interestingly, only one doctor, a young trainee who had spent a year working in rural KwaZulu Natal, had come across the term *isihlambezo*, this being a Zulu term. Apart from this exception, no doctor had knowledge of the terms *masheshisa* or *isihlambezo*. However, all the doctors I spoke to were familiar with this widely used herbal remedy that, allegedly,

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<sup>80</sup> There are in fact several traditional remedies taken over the pregnancy life-course, each with specific uses. A full list of these Swazi remedies, has been compiled by Thwala (2011).



promotes violent<sup>81</sup> uterine contractions and can potentially lead to serious complications relating to precipitate-labour.

*The first time I came across it, I was preparing for a caesarean, and was still doing the paperwork, and a nurse said, ya, the patient has taken some herbal stuff, and I thought nothing of it. I just said [to the nurse] I am coming just-now. And the nurse just looked at me [as if to say] like wake up. And she actually said doctor, this stuff is stronger than oxytocin. Jus! [South African slang: Jesus!], before I know it, she's [the patient] is having the most violent contractions.*

*It was an emergency c-section. She just wanted the kid out, and when I spoke to her she said she was just tired of waiting.*

*Mom was fine, baby was fine, but there could have been loads of potential complications. The amount of oxytocin I would have had to use to simulate that, would have been off the scale. Whatever that stuff is, trust me, there is definitely an active ingredient.*

*Dr Peters*

*When they come in, they're fine. I'll check, and she'll be only four [centimetres dilated]. But then suddenly, after that, the patient is moving [in labour], and we check again and she's still only four! And we ask the patient what did you drink,? I drink the masheshisa.*

*Nurse Magobeni*

*They don't go through the normal stages of parturition. They take this herbal medicine, but then the uterus keeps contracting, because it doesn't know when to stop. It doesn't know when it's over. It just keeps contracting, the patient keeps on bleeding, and then you must give the patients whole lots of medicines. The stay is longer in hospital, with unnecessary punctures, unnecessary drips, unnecessary things. This stuff only causes more trouble.*

*Nurse Diedricks*

Serendipitously, I was able to speak to a *sangoma* who was based in the hospital maternity wing. “You want to know about *masheshisa*?” She asked, as she continued with the administrative duties she had been tasked with that evening. This was our second meeting, following our initial general discussion on African traditional medicine, and how she managed to balance and leverage the ‘foot-in-each-camp’ position she found herself in.

*Masheshisa, can be dangerous yes. Very dangerous. And people can get hurt from it. The problem is that it is not overseen by a professional. A lot of the time, the patient takes it in the ward herself, or the elders of the father give it to her saying that when she is in the hospital ready to give birth, she needs to drink it. So they come in, and without knowing, just drink it. Sometimes they have come in, and they have already taken it. So we have a case when she took it at the wrong time, and now she's in trouble.*

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81 This being the most frequently used adverb by doctors, to describe the effects of *masheshisa* and *isihlambezo*.

*You cannot just take masheshisa just to speed up delivery. There are stages to giving birth, and masheshisa works, but only at the right time to help make it easier for the child to come out. You have to already be in labour, and you have to be dilated otherwise the child, and the mother, can get seriously hurt. There can be big big problems with precipitate labour - uterine rupture, meconium aspiration, amniotic aspiration, foetal distress, haemorrhage, maternal distress... many problems.*

*But its not the masheshisa that's the problem, its because they don't know exactly when to take it.*

*Nurse Magobeni*

I was intrigued by the alleged widespread use of the *masheshisa*. Doctors clearly disapproved of it, as did many nurses. When encountering a precipitate labour, and it is usually assumed that precipitate labour is almost always caused by the consumption of *masheshisa*, a decision needs to be made whether to undertake a caesarean section, so as to try and circumvent many potential complications. Indeed, when I discussed the issue with the hospitals' CEO, she implicated this widespread use of traditional medicine as a key contributor to the hospitals high and apparently rising rate of caesarean section.

*Let me take for example the maternity cases. Traditional medicines might be good, but they can be bad when they give this isihlambezo. Some give it when the woman is not yet in full term of delivery. So in those cases, we see the woman coming in fully in labour, with quite violent contractions, whereas the dilation is not there. It's a complication already. The person has got strong contractions, but the cervix is not ready. And that's why we end up having a lot of caesarean sections.*

*Twenty-five to thirty per cent of deliveries last month were c-sections. That's very high. The national average for a district hospital shouldn't be more than eleven per cent. Last year we were at eighteen per cent, but from January until now, we were have been at twenty-two to twenty-five, and last month twenty-eight per cent. Its very high. There are other factors, but largely I would say, that so many cases are from strong contractions because of isihlambezo.*

*Matron Magodweni*

This observation that *isihlambezo* / *masheshisa* was potentially responsible for the high rates of caesarean sections was intriguing, and, indeed if true, somewhat ironic. This is because a prevailing view amongst some nurses is that *isihlambezo* is not merely a traditional medicine used to speed up labour and delivery, but this speeding-up, is a deliberate and strategic choice on the part of patients to avoid having to undertake a caesarean section.

The assumption, among some of the nursing staff, is that a deliberate choice is made to try and circumvent a biomedical procedure by the consumption of African traditional medicine. These views are, however, expressed by nurses who largely view African traditional medicine to be in direct conflict with Western biomedicine, where traditional healers are

described as using deliberate, and pre-emptive strategies to try and impede their own work as biomedical professionals. And where the object of contention is, of course, the patient body.<sup>82</sup>

In discussing how nurses are said to encounter African traditional medicine within the hospital, both the maternity and paediatric wards, appear to take centre stage. My outlining of these areas, however, is merely the projected views of biomedical practitioners within the hospital who have a particular positioning and beliefs that they project in our interactions. Given the absence of any direct observations of these wards, it would be impossible to verify the size of the projected 'impact' of African traditional medicine on Western interventions. And indeed when I set out on this project, the aim was not to attempt to quantify such an impact.<sup>83</sup>

So while the above accounts are incredibly interesting in themselves, what is perhaps far more interesting was how the interviews undertaken evidence something of the role of biomedical professional, and in particular the assumptions that nurses, who are predominately Swazi, act as brokers in the therapeutic nexus, mediators of culture, and linguistic translators. It is to these matters I now turn.

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82 These are mirrored in similar arguments encountered, in which nurses bemoan patients who come to the hospital who demand, or refuse, certain procedures on the advice of traditional healers. Prominent examples include demanding blood, because the healers diagnosis of the patient's ailment included '*low blood*'. A further, and oft-cited example, includes a refusal by a patient to accept any form of injection, because the healer claims that if an injection is received, then any subsequent treatment from the healer, will be ineffective. Nurses describe this as a cynical and manipulative ploy by traditional healers, to manipulate their patients, and retain their business to the jeopardy of the patients health.

83 Attempts to get nurses and doctors to give ballpark figures on, for example, the number of women using *masheshisa*, and estimates range between thirty and ninety per cent. For the number of cases in the paediatric ward, estimates range from between ten and thirty per cent. With such wide variations, and no definitive 'labelling' of cases – apart from the phrase herbal intoxication, I ceased any attempts to quantify incidence.

### 5.5 *Exploring the role of nurses as brokers of culture*

That nurses position themselves, and indeed have been positioned, as brokers of culture, has received considerable attention in the social sciences. Whether referring to basic competencies such as functioning as a linguistic bridge between physician and patient, or more complex undertakings that include negotiating community, personal, and professional roles and expectations in relation to different therapeutic cultures, the cultural broker role reflects the very real need to tread the marginal space between cultures, and negotiate tension and conflict that might sometimes result from a collision thereof. As outlined in the preceding sections, the potential for tension and conflict arising as a result of overlapping Western and African traditional medicine, is a very real concern.

Jezewski and Sotnik (2001) define cultural brokering as the *'act of bridging, linking or mediating between groups or persons of differing cultural backgrounds for the purpose of reducing conflict or producing change'*. Through a review of the anthropological, health, and business literature, Jezewski (Jezewski, 1995, 1993, 1990) identifies twelve culture brokering characteristics that can involve:

- *intervening in conflict situations when tensions exist in interactions*
- *standing guard over critical junctures in the context of interactions*
- *possessing role ambiguity in the context of brokering and functioning in asymmetric relationships*
- *functioning marginally in one or more systems while brokering between systems*
- *encouraging potential for changing systems*
- *dealing with others positively and cultivating varied social relationships*
- *mediating between traditions*
- *innovating when traditions are inflexible*
- *facilitating communication by translating interests and message between groups*
- *bridging value systems*
- *functioning as a go-between*
- *bringing people together through networking.*

*Jezewski, 1995, p.18*

In her study of the plural medical landscape in Botswana, Evelyn Barbee (1987) argues that *baTswana* nurses occupy a distinct marginal space between Western biomedical and

indigenous healing, and in doing so, give rise to unique dialectical tensions. *baTswana* Nurses, suggests Barbee, occupy two critical junctures, through serving as professional-bridges between patients and physicians, and also as a cultural-bridges to their communities, with the assumption that nurses hold '*beliefs about health and illness from two domains, that of their culture and that of biomedicine*'. (Barbee, 1987, p252-253).

When nurses engage in these critical junctures between traditional *baTswana* culture, and Western biomedicine, tensions might arise from the need to fulfil divergent expectations. In this instance, the divergent illness ontologies between indigenous *baTswana*, and Western biomedicine collide.

Barbee evokes the work of Comaroff (1981) when outlining the ideological positions that nurses might adopt when confronted by the complex dialectic of culture brokering. In this, we have scenarios where: a) nurses might reject indigenous culture and identify solely with Western biomedicine; b) nurses might assert indigenous culture, and selectively adopt western biomedical practices, and c) nurses may pursue an integration of indigenous and Western ideological positions and knowledge systems – which I would argue may also include the corollary of option 'b', i.e. nurses asserting Western biomedicine and culture, whilst selectively adopting indigenous knowledge and practices. Barbee suggests that *baTswana* nurses express ideological positions commensurate with scenarios a and c, with a small handful of nurses rejecting traditional beliefs outright whilst identifying as modern educated professionals, whilst the majority of nurses try and assert a more syncretic approach<sup>84</sup>. Particularly those nurses engaged in rural based clinics, where they reside in closer proximity to their communities, and where they practice under little physician supervision.

Whilst not referring to culture broking directly, the anthropologist Stacy Langwick (2008) nonetheless evokes many of these notions in her exploration of nurses in a Tanzanian hospital. She explores in particular how nurses within a defined hospital setting engage with, and assemble, knowledge across therapeutic domains in their interactions with patients. Whilst the focus of Langwick's study examines how nurses articulate and discern new 'bodies' in the face of the dialectic tensions arising from plural beliefs, she also emphasises the manner in which nurses navigate, and are seen to navigate, the challenges imposed by medical pluralism. Much like Barbee's earlier work, though arguably more descriptive, and

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<sup>84</sup> While Barbee's paper provides an overview of the dialectic tensions in the nursing role, the paper is nonetheless very light on detail and evidence from the field in how this is accomplished.

with a greater inclusion of evidence from the field, Langwick explores the complex interplay between indigenous healing systems, and how nurses engage in various types of mediation as they assist patients in navigating therapeutic options.

A great many parallels exist between Langwick's Tanzanian hospital study and my own in Barberton, regarding the complexities of nurses confronting and navigating therapeutic boundaries with patients. These include, the self-same scepticism of traditional healers, and lamentations of the potential dangers of traditional medicine, and indeed, very similar accounts of nurses confronting concepts of African traditional medicine, and strikingly similar approaches of nurses engagement with patients in the therapeutic landscape. This particular section of the thesis finds a thematic home amongst these older works on culture broking. However, I add to the literature by exploring the critical tensions arising not only from the therapeutic nexus, but from within the biomedical staffing body itself, where clear friction exists between individual views on professional identity.

With five years experience as a professional nurse, and still residing in the adjacent township of Emjindini where he was raised, nurse Nkosi had encountered African traditional medicine many times. From dealing with patient's families trying to 'smuggle' *imbiba* into the wards, to trying to encourage patients to complete a therapy regime rather than sign an RHT, Nkosi was experienced at confronting African traditional medicine in the hospital.

My initial concern in these early stages was exploring how nurses engage with patients using African traditional medicine within a defined biomedical space, and how they positioned themselves as biomedical professionals within this environment. Whilst Nkosi had a great deal to say about traditional medicine within the hospital, it was he who initially prompted me to consider his role as a nurse in a much wider context, suggesting that I extend my considerations of professional nursing roles to beyond the hospital boundaries.

I had initially asked nurse Nkosi whether he had ever encountered a scenario where *tangoma* or *tinyanga* interacted directly with nurses, or patients, within the hospital space.<sup>85</sup> He replied that he had not<sup>86</sup>, though expanded on this by explaining what is often outlined in the prevailing anthropological literature, namely, that a sangoma need not have a patient in close proximity when diagnosing and proposing treatment. Any prescribed 'traditional' treatment

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85 In pursuing this line of inquiry, I was examining nurses reflections on the potential for informal or formal collaboration that might exist between systems. Similar lines of inquiry have been pursued by (Barbee, 1987; Campbell-Hall et al., 2010; Green and Makhubu, 1984; Mall, 2005)

86 And in this, he specifically discounted the two *tangoma* working as nurses.

needed by the patient, could be ‘smuggled’ by family members into the hospital grounds. Of these types of encounters, he claims to have experienced ‘*too many to count*’.

It is at this point that nurse Nkosi changed the direction of our discussion, prompting me to instead consider the role of nurses in the same vein. To illustrate, the nurse explained that his professional nursing role sometimes prompted requests from family, friends, and others within his extended community network in Emjindini township, to make a ‘*house-call*’.

People within his broad network would sometimes contact him to seek his professional advice on whether an ill person required the ministrations of a physician, and a visit to the hospital. He emphasises that his role in this respect does not require him to administer medications or treatment, but instead his role is initially that of consultant, and if warranted, as mediator, biomedical translator, and sometimes a negotiator.

Within the community, nurse Nkosi describes having identified cases of meningitis, pneumonia, and TB, as well as numerous opportunistic infections that serve as foreboding heralds of a more sinister affliction. He also claims to have even identified a case of epilepsy in a child, and in this last instance, had a great deal of difficulty in persuading the family that they should seek help from the hospital, before seeking help from a *sangoma*.

*They thought it was a spirit, but he [the child] was having seizures. I suspected epilepsy, but to persuade the father... it was very difficult. The mother wanted to bring the child [to hospital], but the father not. In the end, the child did go to hospital, but I think that a few days later, the father took him away.*

Nurse Nkosi

As part of his role in these informal call-outs, he describes having to explain and actively persuade a sometimes fractious and combative therapeutic management group (Janzen, 1987), even members of his own extended family, as to the severity of an illness confronted, and the need for a physician's opinion and intervention. The conflict he describes usually revolves around explaining, as respectfully and politely as possible, why an ill person needs the help of Western medicine, while at the same time, he keenly stresses that he in no way makes any assertions about African traditional medicine in such encounters and is explicit about the need to convey a neutral, non-critical, and non-condescending impression of traditional medicine.

In a similar account, Nurse Hlatswayo, a senior with more than twenty years experience divided between Barberton hospital, and the larger provincial hospital in nearby Nelspruit,

opens our interview by describing her scepticism of African traditional medicine. While she concedes that positive outcomes certainly do result from African traditional medicine, she suggests that such outcomes are most likely to be the result of a number of factors. Notably, that the illness was self-limiting and would have resolved in the absence of intervention; that illness-resolution might simply have been the result of a powerful placebo effect; or indeed that a particular herbal intervention has a useful active ingredient that transcends any 'magical' and 'esoteric' claims. These magical and esoteric evocations, she views as merely explanatory frameworks; cultural idioms and narratives so to speak.

Surprisingly, Nurse Hlatswayo, continues by explaining that despite her views, she has a very close proximity to African traditional medicine. Like many of the nurses in Barberton general hospital, one does not need to scratch the surface too much to discover that many have a traditional healer in their close or extended network of family or friends. In Nurse Hlatswayo's case, her younger sister had recently qualified as a sangoma.

Like nurse Nkosi, nurse Hlatswayo was sometimes called upon to help those in her immediate community network. In this case, the majority of requests for advice came from her younger sister, who, when faced with a potentially concerning case in which a patient seeking her help looks seriously ill, sometimes turns to nurse Hlatswayo for advice.

In this respect, she was not merely acting as an indirect cultural broker (she was not seeing her sister's patients directly), but instead describes both her and her sister as mutual brokers. In this instance, nurse Hlatswayo helps to train her own sister in aspects of health and illness from the biomedical perspective, citing the dangers faced by some traditional healers who are sometimes exposed to potentially dangerous infectious diseases. In this, her account comes across as more paternalistic than collaborative.

In both cases above, we have examples of how nurses claim to constructively engage in circumstances in which there is a significant potential for therapeutic overlap. Both were keen to highlight that, in their view, the most fruitful engagement as brokers in the plural medical landscape, came not from within the institutional space of the hospital, but rather out-with the facility, where they could leverage the professional identities to better serve their communities by advocating for the biomedical treatment route. These accounts were not unusual from Barberton's nurses.

*There was this one case when a neighbour was son was very sick, and they called me and asked me what was wrong. He had these symptoms, and I thought it might be a bowel obstruction. But then the parents took him to inyanga who gave him something that made stools come out.*



*I went to see again, but he was not better. I said just go and test at the hospital, and see what they say. They called me for my professional opinion, and I said, yes, there is bewitchment, but this here, I think is not bewitchment.*

*They took him, and he tested HIV positive. He was 25 years old, and had a CD4 count less than 500 at that stage. He went to the clinic and was coughing.*

*I saw his Mother yesterday. When he came home he was still ill, so she said again her child was bewitched. She totally doesn't believe in HIV, but at least I convinced them to take him to test.*

*Nurse Shabangu*

Regardless of nurses espoused beliefs, eight of the twenty nine interviewees disclosed that someone within their immediate network was a sangoma or inyanga. This included immediate family, as well as neighbours, and friends.

### **5.5.1 Doctor's views of nurses as culture brokers**

In Waltraud Ernst's edited volume exploring medical pluralism, Digby and Sweet (2002) examine the role of the nurse as culture broker in twentieth century South Africa. Their theme parallels that of Barbee and Langwick, but is undertaken through a distinct historical, rather than anthropological, lens. Their work explores, in particular, the historical recruitment of Black nurses in the context of early Christian mission hospital objectives, and the widely held assumptions that training of indigenous nurses, coupled with mission work, would serve as a means of displacing local beliefs, and negating the power of 'witchdoctors'.

*"In my own hospital, I have had the loyal help of natives from the beginning... Their help is needed not only in the treatment of disease itself, but also in the task of liberating the Native masses from the ignorance and superstition that shackle them alike in sickness and in health."*

*Gale, (1936, p 543)*

While, historically, there has been a colonial mind-set, and an attempt to leverage native nurses to culturally displace African traditional medicine and 'Witchcraft' beliefs, one would be hard-pressed to find doctors openly voicing such a position in modern day South Africa.

In my own exploration of doctors view's on the role of nurses as culture brokers, most accepted the obvious point that the majority of nurses derive from the local Swazi community, and as such would have been raised in close proximity to African traditional

medicine. They also indicated that nurses, whilst free to hold to personal cultural beliefs and opinions, nonetheless had to conform to professional and institutional expectations. These included the need to subordinate such personal beliefs to biomedical dogma and physician treatment decisions.

Doctors are not shy at pointing out their own obvious limitations and shortcomings in areas of cultural competence when it comes to interacting with patients. And in doing so, they identify the pivotal role of the nurse as a broker of both language and culture, in bridging this gap.

*Nurses are a lot faster getting to the heart of the matter when it comes to traditional medicine, but not just traditional medicine. Any kind of cultural aspect... Like for example I've come across a lot of psychosomatic issues. We have loads of that here. It looks like they [the patient] are completely comatose, and the nurses speak to them and they wake up. But for me to try and speak with them, even through one of the nurses, its very difficult. Often I will leave one of the nurses... I'll look for a genuine [health] issue of course... but I will leave one of the nurses with them for a while. Half an hour later, they [the patient] will say their boyfriend did this and that, and the patient is sitting up awake.*

*Dr Smythe*

Nurses, doctors suggest, are key in brokering between themselves, patients, and indeed patient families, when there is a need to persuade patients of the importance and necessity of treatment. With doctors emphasising that they try to ensure that patients have all the information they need to make a therapeutic decision, often this can only be conveyed through a nurse.

Nurses, then, are seen as advocates for Western biomedicine, much in line with nurses described in Sumaya Mall's (2005) study. In areas of conflict, where traditional indigenous and Western biomedical ontologies collide, physician's assume that nurses allegiances would fall towards the biomedical domain, where they would unlikely challenge clinical decisions. Doctors emphasise the 'professionalism' of nurses, embodying a defined identity commensurate with biomedical philosophy and practice.

These views do not reflect the characterisation of the fluid culture broker role as described by Langwick and Barbee who suggest the existence of a more neutral and dynamic approach to patient interaction in matters of indigenous healing. Intrigued by physician's descriptions of nurses, I explored this very issue by posing a hypothetical situation. Only a handful of

doctors appeared to take this 'hypothetical' corollary - that a nurse might encourage a patient to change from a biomedical to a traditional therapeutic route – seriously.

*I haven't come across that, but if it ever did happen, that would be a complete breach of trust. Maybe not with the patient, but certainly trust with me [as a doctor]... and particularly if sending the patient to the sangoma to get muti that might be detrimental. I can't say for certain this doesn't happen, but I think our nurses know better than that.*

*I don't think it would be possible to work with a nurse if I thought she might be pushing for traditional medicines over our medicines.*

*Dr Petersen.*

Only one out of the eight doctors interviewed thought it likely that nurses might encourage patients in the hospital to supplant biomedical with indigenous treatment, and indeed this one doctor had encountered such an event in his work in another rural facility in the neighbouring province of KwaZulu Natal. He had not done so in Barberton where he had been working as a locum for the past six months.

Both Digby and Sweet, and Barbee, suggest that, compared to smaller community-based clinics that are usually staffed by nurses, nurses in larger institutions with their more complex hierarchies have limited professional independence, and a certain asymmetry in their brokering role which is slanted towards biomedicine.

I was curious as to how doctors opined on the presence of two nurses within the hospital that were also practicing *tangoma*, however, I did not want to approach this topic directly, as some nurses had already been reticent in discussing these two staff members, leaving me with a very clear sense that they did not want to 'out' these two staff.

As such, I once again presented a hypothetical scenario, asking doctors their views on how they might view, and interact with, a biomedical professional, a doctor or a nurse, who was also a qualified *sangoma*. I followed this by asking if they had encountered a colleague working in this dual-capacity at any point in their career.

It was most telling that while all nurses spoken to were aware of the dual role of their two *sangoma* colleagues, five doctors were completely unaware of this. These five concluded that they would likely be suspicious of such an individual, if only because of the conflict of interest.

*Honestly? I'm not sure how that would work. I mean I can't see it happening really. I suppose it does, but what I mean is I can't understand how someone could function like that... But then, I don't know anything about traditional medicine apart from what I see in here.*

*Dr Pretorius*

The three remaining suggested that they would have no problem with it, provided that the individual could find a way to subordinate their ‘beliefs’ whilst working in the hospital. Indeed two of them had heard rumours that there was a sangoma who was also a nurse practicing in the hospital, though they projected an air of dismissiveness at this, as if they had far more important things to contend with.

### **5.5.2 Nurses’ views on their culture broking role**

There are two aspects of the culture brokering role that I consider in my thesis. The first is the role of some select nurses such as Nkosi, and Hlatswayo, Shabangu and others who manage to function outside of institutional pressures, by engaging ‘unofficially’ within the community. This is done in an environment where they are brought in by trusted friends and family to opine on aspects of illness, away from institutional confines, and away from physician observation.

The second issue to consider, is how nurses engage in this culture broker role when placed under greater scrutiny within the hospital, and I was particularly interested in examining whether there might be any evidence that nurses might advocate to patients to follow a traditional, rather than biomedical treatment route.

There was only one instance in my discussions where a nurse disclosed that she would, if necessary, suggest to a patient that they discharge themselves to seek help from a traditional healer. Indeed, this particular nurse described it as part of her role, and in adherence to her cultural values, to suggest to patients, in very select circumstances, that traditional medicine may be a more fruitful route to recovery.

Nurse Simelane said that there are instances in which she feels compelled to advise a patient to self-discharge in order to seek help from a traditional healer. Usually in cases where the attending physicians, being stumped, are unable to construct a definitive diagnosis.

*Patients wont tell the doctor, but they do talk to us nurses. They know we Africans will understand. And personally, if I feel that if it’s a traditional thing, I will advise the patient to go see a sangoma...*

*Sometimes a patient comes in, and they’ll be here for a few days, and the doctor has run tests*

*to try figure out what is wrong, and it's all inconclusive. The doctor even says [to the patient] we're still trying to understand exactly what is wrong. A nurse is supposed to carry on doing what the doctor says, because it's in the hospital, but then, at some point, I might advise the family to go for a second opinion to the sangoma.*

*If it's a traditional thing, the doctor might land up killing the person by delaying them, because some of our illnesses, are deadly.*

*Nurse Simelane*

I enquired of nurse Simelane how she navigated such issues with doctors. Her reply was an emphatic negative: she would in no way tell doctors as they would just not understand. The process, she suggests, involves making a quiet suggestion to patients that they sign an RHT.

Nurse Simelane goes on to explain that patients will frequently test out the waters with nurses, not merely herself, by 'feeling out' whether nurses might be receptive to a discussion on whether being in the hospital was the route they should be taking. Indeed, this probing was confirmed by other nurses in the hospital when I posed a direct question asking whether patients had any expectation of them in relation to African traditional medicine.

The overwhelming response was that yes, patients do often engage in quiet discussions, always out of earshot of any physician or non-Black nurse, on aspects of African traditional medicine. Most queries apparently revolve around concerns whether traditional medicine can be taken simultaneously with Western medicines. In addition, the nurses explained that patients also use these quiet spaces of discussion to disclose, with an 'understanding' nurse, certain information, and in this disclosure recruit the nurse to help make a decision on whether such information was relevant to the doctor.

All nurses, indeed even the nurse who disclosed that they clandestinely suggest to patients that they discharge themselves from the hospital to pursue a traditional avenue, are firm in their views that treatments from either system should not overlap. Indeed, nurse Simelane above, as well as most nurses, essentially advocate that patients utilise the Western biomedical avenue as a diagnostic tool where, if treatment fails to produce results, they are welcome to seek help from a traditional healer.

Significantly, some nurses declared that their role in acting as a cultural broker often brought them into direct conflict with patients, and certain 'directives' and 'demands' given to them by traditional healers. These include requests from traditional healers, communicated by patients, that only selective Western methods be utilised.

*I have a case every now and then where a patient comes in and asks for blood. Last week in fact. This man came in, maybe around forty, forty five. He says I need a blood drip. So I said I will get the doctor, but he said no, I just need a blood drip.*

*I asked what for, and eventually, he says his sangoma says he has 'low blood'. That he needs to go to the hospital to get more blood before he [the traditional healer] can do anything. I said we can't just give you blood because your sangoma says so. Maybe if he [the patient] needs fluids, he can have a saline drip, but the doctor will still have to check. In the end he just left. I don't know if he was really sick or not.*

*Nurse Masilela*

*There is this thing we come across sometimes when a patient comes in very sick. And he refuses any injections or any drips. Then it comes about that the reason they are refusing these things, is because the traditional healers say to them, yes you can go to hospital, **but**, you cannot get any injections. And then they tell the patient that if they do get an injection, then they [the traditional healer] cannot help them. The medicine won't work after an injection.*

*The problem arises when we have someone coming in with something like meningitis, or TB, or some infection where we need to give them injections. But some traditional healers, the ones only concerned with business and money, I think do it deliberately... threaten patients that once they have an injection, then the traditional [medicine] won't work. They make it sound like they are in favour of western medicines, but then they give restrictions, so they are not really collaborating.*

*Nurse Mdluli*

This particular last scenario was raised by eight of the twenty nine nurses including those who espouse positions both for, and against, African traditional medicine. Nurses, acting as brokers of culture, find negotiating and mediating with patients and their families when faced with this particular scenario particularly frustrating. Most negotiations are carried out in domains of ambiguity, where patients present to them, unsure about their malady and its cause, or what treatment to undertake. In recent years, they have been encountering these more 'intrusive' interferences, where traditional healers attempt to be indirectly leveraging Western technologies, while placing restrictions on patients as they engage in future discussions with biomedical staff.

In most instances, nurses see the need to appear as marginal individuals, someone who respects other systems, as integral to their role. And, in the majority of cases, they do not want to directly challenge patients beliefs. Even nurses who use traditional medicines themselves are vexed by the above scenarios, as it removes a key element of the negotiating process with patients, namely the need to appear neutral. For example, within the hospital, their approach with patients is to encourage them to use Western medicine, and they shy away from a discussion of the corollary, that traditional medicine as an alternative should be avoided. In the scenarios above, where traditional healers attempt to leverage Western

technologies, nurses are placed in a position where they have to explicitly collide with indigenous culture, where their role as culture broker is then constrained.

### ***5.5.3 Internal tensions and the culture broker role***

An intriguing aspect of my research on nurses as brokers of culture was to uncover a significant underlying vein of tension and conflict amongst the staff. While I have suggested that doctors largely interpret nurses to be carrying out their duties in a professional biomedical capacity, views amongst some of the nurses themselves do not necessarily reflect this. Indeed certain critical tensions were expressed by a minority of nurses who feel that some colleagues are too accepting of, or too close to, African traditional medicine use in the facility.

*We work with a lot of Black people. The majority of staff - there's only a handful of Coloured and White people, not two handfuls, really just a handful - and the majority is Black people. And all of them believe in it.*

*They [nurses] might say to you we don't allow these imbitas in here, but I know from my own experience, that many turn their back to it.*

*Nurse Dierkse*

Black nurses, particularly those who cast themselves as enlightened professionals, and who shun traditional medicine, would also voice their concerns that some nurses in the hospital were 'too close' to African traditional medicine. These conversations were usually informal, where there was a great reluctance to talk, and where nurses were reluctant to openly criticise their fellow colleagues, in fear that such criticism might be interpreted as cultural intolerance. Most of the concerns expressed about the ambiguous role of their colleagues, centered around an apparent reluctance of colleagues to limit traditional medicine use in the hospital. Most of these nurses refrained from being interviewed, and direct quoting, though the most vociferous of these, Nurse Dierkse, eventually consented to an interview. However, while initially expressing an interest in contributing to the study, she would on every occasion when our paths crossed, leave me with an excuse about why she could not book an interview time.

When we eventually did meet, she disclosed her views on African traditional medicine, which built, crescendo-like, into a full blown polemic against the practice, but particularly

towards nurses within the hospital who, she claimed, let their cultural beliefs conflict with their professional role. She reserved particular vitriol and emotion for nurses within the hospital who were also qualified traditional healers. Indeed, she saw these particular nurses as devious and manipulative. Where others, such as senior hospital management had been appreciative of these practitioners who hold a dual role, Nurse Dierkse and a handful of other nurses had felt that these hybrid-healers, had somehow pulled the wool over the eyes of management. Nurse Dierkse in particular, claims that one of these sangoma-nurses had been encouraging patients to discharge themselves from hospital, so that they she can treat them in a private capacity. She suggests that even other nurses in the hospital have been beguiled by this authoritative and charismatic healer.

*I'll tell you. One of our staff members had cancer. When she found out it was already progressed, but not so far that chemo could('nt) help her, and this traditional healer in the hospital said she was going to help, saying she should not go to the doctor. Seriously. She should not go to the doctor, but instead she should go see her in private at her home. She stopped all the doctors treatment, and she went over to this person in her home.*

*Nurse Dierkse*

As if to illustrate her point, she declares that the nurse in questions is not stupid, in fact she is incredibly wily, and knows that she would be unwise to practice in the hospital space, though she uses the hospital to feed patients to her own 'clinic'.

*She's a nurse, she knows exactly what is going on. What reason does she have to give these people one, two, three? I still don't understand. You can be a nurse, or you can go be a traditional healer, but you can't be both.*

*Nurse Dierkse*

Following this, we veered into a discussion of the constraints she feels placed under, where she feels incredibly frustrated, and where she, and indeed others of a same disposition, feel it impossible to articulate her position and views openly for fear of offending colleagues. Indeed, she pointed out that the very reason she had avoided meeting with me earlier was because she was certain the discussion would have veered towards a criticism of some of her fellow staff, and she was not sure how I would take that.



## 5.6 *Summation*

This chapter has presented a wide-ranging and meandering discussion on a complex institution. The collision of African traditional medicine and Western biomedicine outlined in the first half of the chapter, outlines nurses and doctor experiences within the hospital from a distinct biomedical perspective. The ‘typology’ of encounters are wide-ranging and complex, each with their own challenges when it comes to how biomedical practitioners claim to confront and manage these. Traditional medicine is largely spoken of in terms of how it interferes with Western medicine, though there is a clear and very emphatic positioning from some avenues, that because beliefs should be respected, criticism of African traditional medicine, and patients who rely on African traditional medicine, should not emerge from the staffing body.

The institution is complex, with staff members clearly ascribing to what might well be interpreted as conflicting camps. Health professional who position themselves as rejecting traditional medicine outright are situated side-by-side with colleagues who use traditional medicines themselves.

The concept of the nurse as culture broker spans several roles, with nurses who straddle the divide, and advocate for a biomedical avenue, to nurses who describe their biomedical knowledge being useful outwith the institutional boundaries of the hospital, where, in some instance they are placed in the position of negotiators with family and friends. The chapter also indicates that there are nurses who find the biomedical route limiting, and who feel it is their moral duty to help patients and clandestinely advise them, in some instances, to discontinue Western treatment in favour of a route to the traditional healer. Encountering such admissions was rare, though this was unsurprising, as respondents have to weigh significant risks in making such disclosures.

The above study was carried out in a complex landscape where participants’ responses to my questions were evidently shaped by the pressures of a post-apartheid institution and prevailing political realities where cultural pluralism, and respect for personal beliefs is prioritised. This, as will be discussed, is juxtaposed against Barberton tuberculosis hospital where pressures of political correctness are subordinate to the institution’s primary concerns as a carcerate facility managing a patient body with a highly stigmatising infectious disease.

## ***Chapter 6: Barberton Tuberculosis hospital***

### ***6.1 Chapter Outline***

This chapter focuses on research carried out in Barberton tuberculosis hospital, and explores the views of patient and the facility's staff with regards to medical pluralism and the collision of African traditional and Western biomedicine.

In part 6.2 I discuss the challenges engagement with participants in Barberton TB hospital, and some of the challenges in carrying out this part of the research project.

Part 6.3 is comprised of two case studies, in which I present the narrative accounts of two tuberculosis patients. These case studies focus on aspects of the patients' personal journeys that eventually led them into the tuberculosis hospital, and through these, we obtain a sense of the complexity of the plural medical landscape, and the difficulties in the navigation thereof. Included in these accounts, is an analysis of the participant's stories with respect to Arthur Frank's (1995) and Weingarten's (2001) 'narrative archetypes'.

In part 6.4, I explore the tensions and challenges of medical pluralism within the tuberculosis hospital, and explore the tuberculosis hospital as a site of biomedical power and control.

## 6.2 *Exploring Barberton TB Hospital*

The specialist tuberculosis hospital is a challenging environment to work in, and the hospital leaves the impression that it was as much a carcerate, as it is a healing space; an institution in which sick and largely impoverished Black patients are secreted from society to undergo treatment under strict observation. These impressions were evoked the moment I first bounced over the rutted dirt approach that led up to the guarded and gated entrance.

On the surface, the internal grounds of the facility appeared calm and clinically tidy, with ordered and landscaped grounds surrounding the various offices and buildings. Ostensibly, the only ‘disordered’ element within the hospital were the patients.

The very uniforms donned by patients left me the impression of immured and diseased state-controlled bodies that were subject to a daily program of reform, until they were no longer deemed to be a threat to society. However, as my time within the hospital unfolded, I came to realise that the impression of ‘biomedical-order’ under which patients were drawn, was in many respects little more than a façade that nurses, and indeed some patients, tried very hard to project. The façade of order was stripped entirely away when, in phase four of the project, I undertook a set of informal discussions with a handful of MDRTB patients.

In phase four, following a six month hiatus since my previous visit, I arrived to discover the layout of the facility had changed dramatically. An internal area had been fenced off, and housed within this new ‘restricted’ area were the facility’s MDRTB patients. They were now separated from patients with primary TB by a chain-link fence. And where PTB patients were able to wander relatively freely around the grounds of the facility, the MDRTB patients were heavily restricted in their movements to the much smaller fenced-off area.

Continuing in the vein of the prison-analogy, MDRTB patients were ensconced in this ‘high-security’ area where there was a second ‘internal’ guard posted at their entrance to their enclosure. When speaking to guards, primary TB patients, and nurses, all stated that the guard-post was there to ensure that these ‘dangerous’ MDRTB patients did not leave their enclosure, and wander about the facility. Both drug-sensitive TB patients, as well as hospital staff, feared these MDRTB patients. And in turn, MDRTB patients knew they were feared, and openly complained of the stigmatism and open antagonism directed their way by other non-MDR TB patients.

During my discussion with these MDRTB patients, it emerged that they had been placed in significant risk of developing the more serious and deadly XDRTB strain by the very institution that was responsible for treating them. MDRTB patients, as well as nurses and other staff, had disclosed to me that the supply of vital second-line antibiotics, which are essential for treating drug resistant TB, had been frequently interrupted. This was a terrible and tragic irony, as one of the primary reasons patients are quarantined, is to ensure that they complete an uninterrupted treatment-course under strict direct-observation guidelines.

This revelation held the ominous echoes of Ivan Illich's (2003, 1975) apposite turn of phrase - Medical Nemesis. Over the mandatory minimum six months of hospitalised treatment or MDRTB, the patients I had met were being cycled on and off vital second line medications because of persistent supply interruptions. And this cyclical interruption exposed them to the very real risk of bacterial resistance to second line medications.

The much publicised XDRTB outbreak in the Church of Scotland Hospital at Tugela Ferry, KwaZulu Natal, is suspected to be the result of direct nosocomial infection, where in a very short space of time, the disease spread amongst the bed ridden in-patient population. In my own work in Barberton, I may well have encountered a number of cases of iatrogenic XDRTB infection. The notion that XDRTB might arise out of negligent case management is certainly not a novel idea (Van Rie and Enarson, 2006).

The above is perhaps the best example of the more challenging aspects of this work, where my attention vacillated between my intended exploration of medical pluralism and culture, to the more immediate issues of the efficacy of biomedical treatment and institutionalised direct observed treatment short course (DOTS) therapy for TB. These issues are related, but only tenuously, and largely only because there appears to be a distinct lack of critical analytical symmetry from biomedical professionals, as to the views on the efficacy and legitimacy of these two systems. What I mean by this is that many biomedical professionals have a proclivity in criticising the legitimacy of African traditional medicine, though few turn such a critical lens inward, and interrogate the legitimacy of Western biomedicine in how diseases are managed.

The challenges of working within the tuberculosis hospital did not end at juggling complex and varied lines of inquiry and interests that did not always fall under the ambit of my original study aims. Indeed, the navigation of the facility itself was a constant challenge.

The general hospital, outlined in the previous chapter, was open to the public, and I could wander these corridors with little notice or remark. In the tuberculosis hospital, however, my

intrusion immediately placed me in the position of the observed. It was I who was under constant scrutiny and observation by blue-uniformed tuberculosis patients and wary and suspicious nurses. An unfamiliar White person within a remand facility that caters almost exclusively to Black patients draws significant attention, and excessive scrutiny, to the point where I felt very self-conscious of my position.

The hospital is challenging in another respect in that it is incredibly easy to fall into the trap of labelling immured individuals as ‘patients’, as if in some manner they had lost their status as ‘people’. They had been downgraded, appended with a new social, and institutional-label, deemed no longer safe to be around, and in a very real sense, not entirely trusted to follow therapeutic direction.<sup>87</sup> Individuals removed from social and familial networks and placed in the enclosed walls of an institution closely associated with notions of disease, illness, dirt, bodily pollution, and death. But of course, when listening to patient narratives, one gets a deeper and richer sense of their personal lives, and how TB has altered these, often irrevocably. In short, the ‘person’ behind the ‘patient’ starts to emerge. Kleinman once remarked of one of his earlier seminal texts on narratives: *The Illness Narratives told stories of sickness much as they had been told to me. I felt a deep compulsion to retell these accounts.* (Kleinman, 1995, p. 14)

A deep compulsion to retell the stories told to me, is certainly the most appropriate way to describe my feelings on this particular facet of my fieldwork experience. Every time I glance over words from my collected narratives, I am transported back to the grounds of the TB hospital. I can still see expressions, and register the tenor of half-whispered voices.

Whilst it was a privilege to have been given the opportunity to engage with staff within both hospitals, as well as a range of people across the town and surrounds, there was nothing as humbling as sitting across from a patient - a person - and listening to them recount the story of their immediate predicament. These were complex stories of health-seeking, of meandering between healing systems, and of the struggle of long-term confinement. These were accounts of stigma and pain, both physical and psychological, directed towards them from others, and, in many instances, self-directed. These were stories of being separated from parents, children, and friends, of the fear of potential treatment failure, and underlying this, the very real fear of death. These were stories of lives in suspension, lives of hope and despair, submission and struggle. The noted sociologist Arthur Frank (1995, p. 54) writes in

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<sup>87</sup> The literature on chemotherapeutic adherence for TB, as well as critiques on the biomedical notion of ‘patient adherence’ and ‘non-compliance’ is broad. see (Greene, 2004; Harper, 2010; Munro et al., 2007; Volmink and Garner, 1996; Volmink et al., 2000)

his celebrated work ‘The Wounded storyteller’: Whether ill people want to tell stories or not, illness calls for stories.

But this chapter deals with more than just stories of ill people, as of course stories of illness does not only affect one individual, but can draw in both family and friends. In this respect, a number of discussions about the plural medicine landscape emerged not only from specific narrative interviews, but also from a variety of respondent and informant interviews. And to fully understand the complexity of TB treatment in a plural medical environment, these too need to be considered.

This is perhaps best demonstrated by recounting an event conveyed to me by Thandiwe, an administrator in the general hospital which is sited only a few kilometres away. This particular even, whilst not conveyed in a narrative interview, nonetheless speaks to the complexity of TB treatment in a plural medical landscape, and perhaps also demonstrates the methodological challenges in trying to weave together accounts deriving from different data collection approaches.

Thandiwe’s Uncle had been in the tuberculosis hospital for two weeks when she got a text message asking her to bring him some meat and bread. At that particular time, patients were permitted to cook food on an old rickety stove, though by the time of my arrival, this privilege had been removed. Thandiwe stated that she disliked going to the hospital, but because he was an elder, and she a dutiful relative, she did as she was asked.

A similar message came the week after, and once again she steeled herself to cross the guarded gates of the TB hospital to deliver bread and meat. On this second occasion, she couldn’t help notice that her Uncle was visibly thinner and very much weaker.

A message didn’t come the third week, but she took meat and bread anyway. When she got to the tuberculosis hospital, and navigated her way to her Uncle’s residential-block, she found his bed empty. Approaching the nurse on the reception desk, she enquired of his whereabouts. ‘Who is your uncle?’ was the reply, followed by a process of matching his name to hand logged journal records. ‘Oh, sorry sisi. He died yesterday’ came the reply.

This abrupt revelation was followed soon after by a request for her to empty out his bedside cabinet. Still digesting the news of her Uncle’s passing, she returned to the now vacant bed, and in emptying the cabinet beside it, she found two items of interest. The first was a nearly empty bottle of imbita, and the second was a dried-out husk of a hollowed-out half-loaf of bread, the crust now as hard, and indeed probably as edible, as cardboard.

*‘Hollowed out like a... like a bunny-chow...’* said Thandiwe, referring to the popular meal of a hollowed out half-loaf of bread which serves as an edible tureen into which curry or stew is placed. *‘And you know what was inside, a whole pile of those big TB pills!’*

Apparently the nurses had known nothing of her Uncle’s use of traditional medicine within the hospital, and neither, it seems, were they aware of his apparent ‘non-compliance’ and his squirrelling away of his chemotherapy.

*‘They (nurses) are supposed to observing him drink the pills!’* exclaimed Thandiwe, well aware of the direct observation treatment protocols for TB treatment. Thandiwe did not criticise her Uncle for what appeared to be a substitution of chemotherapy with imbita. In her opinion, the nurses had failed to adequately carry out their duties and ‘police’ his treatment-course.

### **6.3      *Narrative case studies of patients in Barberton Tuberculosis Hospital***

In this section, I present the case studies of two individuals, Bongani and Nolwazi (not their real names) in which I explore narrative accounts of their meanderings through a plural medical landscape. I also explore how their accounts can be examined and understood in relation to meta-narrative typologies (Frank, 1995; Weingarten, 2001).

This part of the chapter falls squarely within the genre of illness narrative, or more specifically, under the rubric of *illness as narrative* (Hyden, 1997) or *personal experience narrative* (Labov, 1972). Bongani's and Nolwazi's accounts are not merely stories of reconstructed experience, but are stories mediated and shaped by a multiplicity of factors, including the cultural and institutional landscapes from which they emerge.

#### **6.3.1    *Exploring illness narratives***

The subject of narratives, as used by social scientists, is broad, however, there are a number of key elements deriving from the illness-narrative literature I wish to touch upon, both in general terms, as well as how they relate to the narrative accounts of the two patients within this chapter.

At its most basic, narratives are stories with structure, told to try and convince an audience that certain events happened to a narrator, and as a result of such events, the narrator was in some way affected (Riessman, 1990). Narratives differ significantly from informant and respondent interviews, in that they are conveyed within a temporal framework, constructed with a beginning, middle, and end - though they might not necessarily unfold in strict sequential order. Indeed, there are many ways to construct a narrative, and temporal-shifting can effectively be used to dramatic effect in the art of story-telling.

Narratives also contain familiar literary elements that include characters, scenes, plots and themes, movements and acts that shape the account. Furthermore, they are not merely recounted experiences bound within a temporal frame, but the manner in which they are constructed, or rather reconstructed, and the context in which they are conveyed, provides insight into an individuals' representation of motives and moral positioning in relation to described past events.

With regards to illness narratives, patients do not just recount narratives of events, but their telling thereof is constrained by social and cultural convention and boundaries, as well as



power and positioning in relation to institutions and individuals. Including the positioning of the storyteller in relation to his or her audience. In this case, the audience is of course myself, a White educated healthy individual, exploring stories of immured Black men and women within a heavily regulated institutional environment that effectively contains a captive audience.

Bulow (2008) suggests that our need to use narrative accounts in conveying illness is both literal and existential. That is, we both communicate our disposition and use narrative to explore and explain the story of our illness and how it comes to define, or redefine, our life story and trajectory. To phrase it another way, narratives are: *"the primary scheme of which human experience is rendered meaningful"* (Polkinghorne, 1988, p. 11).

Hydén (1997) identifies at least three general types of illness narrative based on the inter-relationship between narrative, narrator, and illness. These are: illness *as* narrative, narrative *about* illness, and narrative *as* illness. Regarding the first, illness *as* narrative, illness is expressed through narrative, and in this Hydén approximates this typology with Labov's (1972) concept of the *personal experience narrative*. This narrative-type conveys an account of personally experienced events and circumstances, and how illness shapes, and in turn is shaped by, the narrative account. Hydén draws inspiration from Kleinman's (1988, p49) celebrated text on illness narratives to emphasise this typological distinction, emphasising that: *"the personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering."*

In the second instance, narrative *about* illness generally concerns professional biomedical perspectives about illness. The narrative is considered an important aspect of the process of compiling and imparting clinical knowledge. In this, the biomedical professional is charged with understanding, and translating the individual patient's narrative account, and from that, to then be able to diagnose a 'biomedical' ailment, as well as convey information to the patient in a manner in which there is an element of narrative consistency.

This narrative category is concerned with the translative and interactive dimensions of illness - narratives as they occur within the clinical encounter, that clinicians are required to interpret. They are stories of how patients themselves understand and describe illness experience. (Good, 1994; Mattingly, 1998, 1994).

Narrative *as* illness, the final of the three typologies, usually concerns instances in which people are not able to effectively use narratives to articulate and structure events and experiences. Examples most often cited are instances in which an individual might be

suffering from brain injury or trauma, and as a consequence are unable to adequately leverage narrative ability to articulate and order events.

Hydén's three narrative types, of which we will concern ourselves with the first and second within this thesis, were formulated as a result of dissatisfaction with prevailing narrative typologies of the period, specifically Arthur Frank's frequently cited '*restitution*', '*quest*', and '*chaos*' narrative types. Hydén's primary critique with respect to these, revolves around the limited set of narrative genres upon which these are based. However, in his celebrated work 'The Wounded storyteller', in which these narrative typologies are discussed and explored at length, Frank states that the *restitution*, *quest*, and *chaos* narrative types, are by no means meant to be collectively exhaustive. And this is demonstrated by Weingarten who draws from Gergen's (1994) work on story linearity and trajectory, to discuss the '*stability*', '*progressive*' and '*regressive*' narrative archetypes (Weingarten, 2001). I wish to take a moment to briefly outline both Frank's and Weingarten's typologies, as I draw from them in exploring and drawing a deeper understanding of Bongani's and Nolwazi's own stories.

The *restitution* narrative, quite simply, conveys a desire for the afflicted to return to a state of health, and concerns a search for diagnosis and effective intervention (Frank 1994, 1995). Weingarten describes the restitution narrative as the "*...most preferred story in Western cultures*" (Weingarten, 2001, p. 3) which is told and described from the perspective of diagnosis and intervention. Medicine, and the medical establishment, assume the role of protagonist in the restitution account, while the voice of the narrator recedes somewhat into the background. Frank (1994) describes the restitution narrative as having limited narrative possibilities, where the dominant 'voice' is not necessarily the patient's. Aligning somewhat with the notion of the Parsonian sick-role (Parsons, 1951; Siegler and Osmond, 1973), the role of active storytelling in this narrative archetype does not originate from the patients voice, but rather the physician or nurse guiding and directing the patient through to a state of health.

The *chaos* narrative is described as one in which the story is incapable of being told, and indeed, they are rarely heard. Those in the midst of chaotic events are unable to structure and voice a coherent narrative. To do so, requires space and reflection, and distance from the maelstrom of a chaotic event. The value in a chaos event, then, is arguably embedded in the silences, what is left unsaid, as much as what is said. Frank, (1994. P.7) describes a pure chaos voice as one in which there '*is a hole in the narrative*'.

Described by Frank as the most common narrative type, the *quest* narrative defines illness as a journey. One in which the protagonist's illness is interpreted as a call, followed by a period of trial, and tribulation, all of which culminates in a return. A return in which an individual has undergone an irrevocable altered-self as a result of the suffering experience. Indeed, the journey of the sangoma is a perfect analogy for the quest journey, given that their induction begins with a call marked by a period of turbulent illness, moving through a quest of enlightenment, culminating with a dramatically altered self. While not referring directly to narrative theory, Ria Reis' (2000) discussion on the journey of the 'wounded' *sangoma*, carries strong echoes of this.

Weingarten's *stability*, *progressive*, and *regressive* narrative archetypes, are essentially linearised plotted stories, in which the end, or project end, is evaluated with regards to the illness experience as a whole. For example the stability narrative, as one might foresee, tells an illness story in which the individual fares no better or worse over a plotted period. The progressive narrative describes a story in which there is continual incremental improvement – and they are arguably the types of stories in which we enjoy being situated as an audience. The regressive narrative is of course the opposite of the progressive narrative, one which characterizes a state of constant declining health.

The purpose of classifying narratives typologically is not to categorise or pre-judge an individual: "*Stories are not materials to be analysed*" writes Frank "*they are relationships to be entered*". I will return to an examination of narrative typologies, following an analysis and presentation of Bongani and Nolwazi's accounts.

### **6.3.2 Bongani and Nolwazi**

I met Bongani and Nolwazi on separate occasions at the grounds of Barberton tuberculosis hospital. Bongani (21) was being treated for Multiple Drug Resistant tuberculosis and had been resident in the facility for five and a half months, while Nolwazi (20) was nearing the end of her three month course of treatment for Primary Tuberculosis, and was expecting the next sputum test result to indicate that she was well enough to be discharged.

Until falling ill, both had been working in retail positions, commuting from Barberton to the town of Nelspruit on a daily basis, and both stated they were studying part-time for their

National Senior Certificates.<sup>88</sup> Both spoke fluent English and Swazi as well as some Afrikaans, and our interviews were conducted in English. Both also engaged in follow-up discussions within two weeks of our initial interviews, and further informal discussions followed this.

Our one-to-one talks were initiated with an informal introduction in which I outlined my purpose and study aims, and my interest in how people navigated different healing systems, and that I was interested in hearing about their own personal experiences conveyed in their own words, with a particular interest in how, and when they had realised they were ill, and what treatment avenues they might have followed to address their ailment. I also stated that I was interested in how they had come to be diagnosed with TB, and how they had found their way into Barberton Tuberculosis Hospital, the most current chapter in their, and indeed our intersecting narratives. Above all, I encouraged them to tell me their stories.

My discussions with both Bongani and Nolwazi were held on an individual basis, in various locations within the hospital grounds.<sup>89</sup> Both were eager to tell their stories, though for very different reasons. Bongani emphasised, in particular, that biomedical practitioners were unconcerned about his own illness story, showing little concern for his experiences that lie beyond issues of immediate clinical importance. He describes feeling like an object, a body reduced to the infectious disease it contains, as nurses and doctors focus primarily on the fundamentals of clinical significance. Or at least that is how he portrays his position as being pigeon-holed into a prevailing institutional narrative. An 'MDRTB patient' who in the past 'must have' been wilfully negligent, a treatment defaulter, to have developed drug resistant TB.

*Nobody here, none of the nurses or the doctors had asked me these questions. None of them I think are interested in my own story. All that is important to them is that I am MDR. They already think I am here because I'm defaulting.*

*Bongani*

Nolwazi presented a very different narrative account, using our discussions to convey an impression of someone adhering to a classical Parsonian sick role. She talked of nurses and doctors in benevolent terms, and labelled those who did not conform as 'deviant' and

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88 South Africa's school-leaving qualifications roughly equivalent to British 'A' levels or the International Baccalaureate.

89 It was requested by the hospital senior management that my discussions with all patients should be held outdoors in the open air to reduce the risk of exposing myself to infection.

irresponsible. The doctors and nurses, as far as she was concerned, knew best. Nurses within the facility spoke of Nolwazi as a model patient who did what she was told, did not argue, and always took her medications exactly as directed.

Through Nolwazi's account we can identify an element of dramatic conforming. Not only did she do as she was told, she actively wanted it noticed that she did what she was told, and to be seen to be fulfilling all necessary institutional requirements for TB therapy.

I should also state that the horizons of both Nolwazi and Bongani had for some months been severely curtailed, and both claimed little in the way of visitation by family. While it is common to see outside family visiting interred relatives, Bongani's and Nolwazi's respective families had apparently visited infrequently despite them living only a short distance away in Barberton township. They both attributed this 'arms-length' treatment to the stigma of being infected with TB, as well as being interred in the '*hospital of death*', as the tuberculosis hospital was known in the community (Dr Machaba, pers. com). Given their infrequent interaction with the outside world, there is little surprise that both Bongani and Nolwazi were eager for the chance to talk with someone who was not a doctor, nurse, or fellow sufferer.

Finally, of further importance in their eagerness to relate their stories, was that the topic of medical pluralism resonated with them. Both had stories to tell, and both wanted their stories told. For Nolwazi, the telling of her story revolved around her desire to convey an account not only of her own illness journey and experience, but significantly that of her now deceased brother. A sibling whose death she attributes to him placing greater trust in traditional healing over that of Western biomedicine. Her own illness journey and experience, and her decisions in relation to this, are effectively an extension of the story of her deceased sibling, where there is a strong element of 'narrative-continuity' from the vicarious experience of her brother's 'fight' with TB and AIDS.

From Bongani, we have a narrative that sees him weave through multiple therapeutic avenues, with an emphasis on his requirement to conform to familial and cultural expectations in his health-seeking journey. His story is one of searching for answers, but also one of apparent confusion, a young man subject to the will of the wider therapeutic management group.

In the following pages, I present Bongani's and Nolwazi's voices, and explore their use of narrative in describing their individual experiences. I explore what, and how they convey their stories, and how through a reconstruction of their past, they define their roles, and moral positions as protagonists navigating personal illness, institutions, culture, and the web

of power and influence that connects these. Through their accounts, we can begin to understand some of the complexity of trying to navigate Barberton's various institutions in their search for an elusive state of health.

### 6.3.3 Bongani's narrative

We perched on warped wooden benches in a secluded corner of the hospital grounds, shaded from the noon-day sun by overhanging boughs of a flowering Jacaranda tree. Despite the warm weather, Bongani complained of chills and, like most patients, was clothed in pale blue pyjamas and shrouded in a matching robe. The latter bearing the label BARBERTON TUBERCULOSIS HOSPITAL across his back in red-block Arial.

Bongani faced the enclosed world of the hospital appearing small, hunched over, as if beset from all sides. A posture that did little justice to his otherwise tall six foot frame. He sidled around the hospital grounds with a bent posture, stooped shoulders, soft knees, and limp arms thrust deep into gown pockets. At twenty one years, he shuffled with an economy of movement I imagined in a man four times his age.

Bongani's voice emerged thin and soft as he spoke, and the taut skin around his eyes and mouth accentuated the occasional grimace of physical discomfort. This discomfort he ascribed to his MDR therapy, daily shots of medications that leave injection sites painful and raw. This compelled him to shift a frail and protesting body on the twisted wooden bench, continuously seeking the least uncomfortable sitting position. Bongani was also one of the unfortunate patients to be suffering from ototoxicity, a treatment side-effect of hearing and balance loss resulting from the anti-tuberculosis medications (Bardien et al., 2009; Duggal and Sarkar, 2007; Törün et al., 2005). This only added to his anxious disposition. On that first meeting I assumed he was having a particularly bad day and offered to reschedule. This prompted a hollow laugh followed by a resigned "*There is no good day*".

Bongani began his narrative by trying to establish a temporal frame for his story, trying to recall the moment he first realised he was ill. Working backwards from the time he had already spent in the tuberculosis hospital, he settled on an estimate of between twelve and thirteen months prior to our meeting. Bongani's narrative holds all the elements of a classic journey - the recognition of illness and a quest to seek answers about his disequilibrium from 'knowledgeable' people, a cast of characters whose intentions, though not initially clear at the start, emerge as the story unfolds. In each narrative-act, Bongani describes a series of events, experiences, his decision-making rationale, and the

relationship between himself as the protagonist and various characters. In his account, TB itself can be thought of as a character lurking in the shadows, ambiguous, unformed, and indistinct, waiting to be unmasked and named.

*B: I cannot say exactly when I started feeling ill. It was over a year ago now, maybe a bit more. I was starting to feel ill, was coughing, and I had these pains in my chest. So I thought let me go to the doctor.*

*He said it was pneumonia and he gave me these pills. I took the pills and the pains they disappeared, so I thought, ah, it's just pain. But after about a week later, I felt it again, and I felt very ... very heavy. I had it for about three weeks and I was taking those same pills for the pain again.*

*P: You took the same pills? Did you go back to the doctor to get them?*

*B: No, I got them at that time because I used to work at Clicks [a chemist], but I don't know if it was because of the pills or because I was sick that made me feel so tired and dizzy, but the thing is I would sometimes get dizzy and fall asleep.*

*So then I went back to the doctor again, and he said go to the hospital and get an x-ray, and when they showed me [the x-ray] they said your lungs is not good. They gave me medications, I drank it for three - four months like they said, and it got better, but then only a few weeks later, it started to get worse again. The heavy feelings, and the pains they started to slowly come back.*

*Because I am African, my elders they said **no** - this here, this pains, all this problems I am having, the heaviness, this is witchcraft, the batsakatsi [siSwati: witchdoctor], so it was then they took me to a sangoma so she can see what is wrong.*



Bongani's initial diagnosis for his ailment is described as pneumonia, but this is then alluded to as something less determinate requiring some months of treatment following an x-ray. What stood out, while listening to this initial introduction, is the manner in which he summarises, glosses over even, a period of biomedical treatment that, with the aid of later discussions, I estimate to be between four to six months in length. This introduction came across as somewhat ambiguous, fuzzy, with little in the way of definitive description of his experience, or his illness apart from an apparent initial diagnosis of pneumonia for his lung condition, a diagnosis which he claims was unsuccessfully treated.

Following the x-ray, and the observation that his lungs were '*not good*', Bongani does not elaborate about a '*three - four months*' course of treatment. I suspected, though was not able to confirm my suspicion, that this may have been the first occasion Bongani received treatment for tuberculosis. An unsuccessful course that might account for the strain of MDR he was being treated for at the time of our meeting.

I decided to hold back from delving into the finer detail of this initial act until much later. My intent had been to revisit this initial chapter once Bongani had completed his story, but over the course of the narrative, a number of issues arose that made me hold back my questions until a follow-up visit. Key among these being that upon eventually learning that he had MDRTB, Bongani describes being interrogated and criticised by nurses for having defaulted on previous TB therapy. Therapy which Bongani claims not to have undergone. Bongani was very aggrieved with these accusations, and the characterisation of him by nurses as a defaulter by default.

Discussing this alleged treatment with Bongani during a follow-up meeting a week later, I carefully ventured the possibility that this may have been for TB. He replied: '*I don't know if it was pneumonia or TB or something else. The doctor and nurses just said I must finish all the pills which I did ... maybe if it was TB...*' he ventures as if to consider the possibility, but then pivots almost immediately '*... but if it was then why didn't they explain it to me?*'

In both discussions, Bongani came across as defensive and reluctant to dwell on these months in any great detail. Highlighted in this initial act is the implication that while

Western medicine may have provided temporary respite, it was ultimately unable to affect a cure.

Months of treatment, or apparent treatment, had, if not for Bongani then certainly for his elders, proved to be of limited use and left the impression that the biomedical approach was ineffective, incapable of *seeing* what was wrong. The inefficacy of the biomedical avenue in addressing his malady only confirmed the suspicions of his elders that sinister forces, the batsakatsi, were at play. It is at this point that Bongani feels the need to make reference to his African-ness, both an interesting evaluative clause, as well as a segue for the act that follows.

There are a number of explanations for Bongani's reference to his African-ness. The first being his need to qualify and justify forthcoming actions and decisions to me. Indeed, the phrase *because I am African* comes across not only as a segue, but as a deflection of sorts, on the expectation that I am actively judging his narrative acts and decision making. We might easily replace *Because I am African* with *Because of my culture*.

Secondly, I suspect Bongani's reference to his African-ness also allows him to justify and legitimise the actions and choices he is about to impart to me, by positioning himself as being ignorant at the time. He is, to an extent, excusing the actions of his protagonist-self as someone who did not know better, and compelled to seek help from an African traditional healer by other characters in his account. He goes on to describe how he had to acquiesce to the collective wishes of his elders – his extended therapeutic management group (see Janzen and Arkinstall, 1982; Janzen, 1987).

In the next segment of Bongani's story, he describes being taken to a sangoma by his elders where the 'down x-ray'<sup>90</sup> – bone-throwing, otherwise known as *tinhlolo* in siSwati - is used to scry, the nature of his malady. The resulting interpretation of his illness is one that confirms the suspicions of Bongani's elders that metaphysical forces are at play. What does not emerge from a plain reading of the text that follows, is the veneer of

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<sup>90</sup> I encountered the term *down-x-ray* several times in and around Barberton. It is a common reference to *tinhlolo* - i.e. divination through bone throwing. The act and skill of a healer being able to cast and look over bones, i.e. looking down, is analogous to the clinical x-ray. The analogy in the act of 'seeing' through obstacles. This analogy has been drawn elsewhere, (Thomas, 2007)

scepticism that Bongani begins to affect when talking about the traditional healer, her methods, and her explanation about his illness.

*B: She [the sangoma] said your neighbour is fighting with you because you are working now. Now you are coming all- right. You have a good job, and your neighbours are fighting with you because they are jealous. She then told me all of these things about how my neighbour stole my trousers, my work trousers were hanging on the washing line and she said the neighbours stole it one day, and they took a chicken and killed it and sprayed some of the blood onto the trousers to bewitch me.*

While Bongani positions himself as someone sceptical of the sangoma, it is not initially entirely clear whether his scepticism hinges on the veracity of this particular sangoma's claim of bewitchment, or whether he finds the entire notion of bewitchment itself questionable. Or indeed neither, and the sceptical position is affected for my benefit – the White audience to which he is positioning himself.

Accusations of witchcraft revolving around economic disparity within small communities are not uncommon, and indeed can run in both directions. The poor may be accused of practicing witchcraft because they are envious of the wealthy, and conversely those who accrue significant wealth, may be suspected of using dark magic in this pursuit (Golooba-Mutebi, 2005; Niehaus et al., 2001).

In the following account, it appears Bongani's status, his securing of a good job, leaves him open to attack from jealous neighbours. The characterisation of Bongani *coming all-right*, is the sangoma's description of Bongani as a responsible adult, someone pursuing a good and moral path. While it might serve as a useful platitude from the sangoma, it also establishes the beginnings of a framework from which the sangoma can position the notion that Bongani's affliction is not his fault. He is not ill because he has done something wrong, or because he has breached some moral delict. Instead he is ill because he has done something right, and has been the victim of jealousy.

While it effectively locates Bongani as a victim of circumstance, it also comes across as an act of pandering on the part of the sangoma. Despite his veneer of scepticism regarding the sangoma's claims, Bongani does refer to his protagonist-self within his narrative as someone who is striving to be responsible, to better his education, and securing a much-prized job.

Bongani continues by describing the sangoma's interventions, and his response thereto.

*B: She [the sangoma] gave me a medication, and I had to wash myself with this medication. I felt cramps all over my body. Very painful cramps all over so she gave me this other medication and said ya, [okay.] you must drink half a cup every day.*

*But after two days! [I was] Dizzy! Shock! Like there was electricity in my body! Like [pause] like a shocking feeling all over! I was like so stiff! I could feel that whatever she gave me was not working, and I felt like I was getting worse very quickly.*

*I wanted to go somewhere else, but my elders they said **no**, you must go back [to the sangoma] again. I drink it [imbiba], for three, four days, but nothing [shakes head]. I can't get help. The pains were still there, and she could not help, I was getting worse.*

*I decided again, no. These things so far doesn't work, it was not helping. So I decided no, and they [the elders] said no, how about there was my uncle. He goes on church, the ZCC, [Zionist Christian Church] and he believes that that God can communicate in another way. So I go and try the ZCC to see what **they** see about me.*

Up until this point Bongani conveys himself as a protagonist unsure as to the cause of his disequilibrium. Where the biomedical and African traditional avenues have so far proved inadequate and unsuccessful in treating his illness and providing a suitable diagnosis for his disposition and cure for his pains. His initial request to seek help elsewhere is denied by his elders, and he is subsequently required to spend more time consuming what he

later describes as a very bitter concoction of traditional medicine. In a follow up interview, I asked Bongani if seeking help from the ZCC was his idea, to which he replied it was a joint decision between himself and his elders.

While a vein of scepticism is woven into Bongani's description of his time and treatment with the *sangoma*, this is not so when discussing the efforts of the Zionist Christian Church in the event that follows – at least not at this point in the narrative. He does however begin this section with the qualifier that, having never been to the ZCC, he had no expectations whatsoever about what would occur, and was only following the guidance of his Uncle who accompanied him. The resulting diagnosis he receives surprises him somewhat.

*B: At the ZCC, you know what they said? They said your neighbour is wanting you to die. Your neighbour is jealous because your father is working very good, with a big house and a nice bakkie [a 4x4 SUV]. Eish! [slang: In this context it expresses surprise: Wow!], I was surprised the things they said was similar to what the sangoma said, not exactly, but similar.*

*But you know whenever you go to a sangoma, or any of those traditional healers, so often they say whatever is wrong with you, the problem is your neighbour. [Bongani lets out a hollow chuckle]*

*It's always your neighbour, [shakes his head], but you know they never say which one! And then at the ZCC, they said the same thing, that my neighbour was to blame, but this time because my father has a good business.*

*They told me to go and buy some things to make a drink, they call it indayela. They said I must go and buy Five Roses [a popular brand of tea], cocoa, coffee, fresh long-life milk, and some salt. They boiled it all with water and made a drink called indayela. They said it is like tea, but it is supposed to fight evil spirits.*

*P: So you know all of the ingredients in Indayela?*

B: *Yes, but you cannot do it at home. You cannot just buy the things and go make it in your kitchen. They have to do it there at the church so that they can pray and bless it, and they have to pray for you there too. And when you drink it, you can feel it. [pause] You can feel it working on your system.*

*It was like I wasn't feeling so heavy and slow. I was still in pain but maybe a bit less, but the only problem it was terrible to drink.*

*They said I had to drink indayela for a week, but after three, maybe four days I couldn't drink it anymore. It was just too... too sour!? The imbita was slightly bitter, but I could drink it. Indayela was just too sour, I wanted to [drink it] but I just couldn't anymore. So after three-four days I stopped.*

Unlike the imbita dispensed by the sangoma, Bongani is privy to the ingredients of the indayela, and he clearly makes an assumption as to where I am going with my question in relation to this, and is quick to reinforce the numinous and esoteric. “*You cannot just buy the things and go make it in your kitchen*”. He is also very careful to ensure that he does not criticise the methods or practice of the ZCC apart from his dislike for the taste of indayela, and even then he attributes the failed, or in his opinion curtailed, treatment to his own inability to finish the unpalatable concoction. Bongani claims the treatment to have been working otherwise. Unlike the sceptical tones with which he discussed his treatment at the *sangoma*, he expresses what appears to be genuine surprise that the ZCC’s account of the source of his malady, was so strikingly similar.

Given the array of ingredients in the *indayela* concoction, I can understand why the drink may be unpalatable. Indeed, I encountered many similar accounts from nurses and patients on the, sour / bitter concoction that is *indayela*, with a similar list of ingredients. While Bongani is careful not to criticise the ZCC, and describes himself ‘*feeling*’ the treatment working. His admission that the burden of treatment failure rested on himself, comes across as a little too convenient.

I was at this point considering whether Bongani was trying to convey the impression of himself as someone sceptical of the traditional healer’s therapeutic narrative, and indeed the ZCC’s narrative, with regards to witchcraft and magic. Both the ZCC and the

sangoma describe his ailment as being the result of malign forces, Bongani being the victim of the 'evil eye'. Indeed, the explanation from the ZCC reinforces the notion, particularly to his elders, that his malady may have arisen because of malign and magical influence. However, saying this, he is somewhat flippant about traditional healers: *But you know whenever you go to a sangoma or, or any of those traditional healers, so often they say that whatever is wrong with you, the problem is your neighbour. [laughs] It's always your neighbour, but you know they never say which one!*

When Bongani decides he is unable to continue with the 'sour' treatment, he is once again taken to a traditional healer by his elders, though this time a different one. He tells me that his chest problems are now getting worse and that he had lost a good deal of weight.

*B: I was still feeling ill with pains and now I was coughing a lot more than before. My elders they said no, you must go back to a sangoma again. A different one this time, but this time I didn't drink the same imbita.*

*The sangoma, he was a man this time, he said the same thing again, that my neighbour is jealous what-what-what, [slang: roughly translated in this instance as et cetera... though in a more pejorative vein: blah blah blah] and he told me there was something in my chest and he needed to get it out.*

*He took muti and put it on the coals, on the fire, and then you have to inhale the smoke with a bamboo. It was painful, my chest was already very painful, and I coughed and coughed.*

*The sangoma made me cough into a bowl and something came out! These dirty things with the sputums. It looked like... like brown... sticks? Like very small... [Bongani picks up some twigs off the ground to demonstrate] ... exactly like this but smaller, in the sputums.*

*I was shocked that these were inside my chest! I was completely exhausted after that, but after coughing that up I did feel better. I went home, and I felt better for maybe one day.*

*The pains came back, and I was coughing coughing, much worse than before, and that was when I finally said no. I said to my elders to please. Please please let me go to the clinic again.*

Bongani, once again, emphasises that he is under the direction of his elders as he goes to see the traditional healers, and, once again, he dismisses the sangomas therapeutic narrative almost impatiently with his ‘what-what-what’ qualifier. As if he has lost patience, and could not be bothered to re-explain the traditional healers take on the cause of his malady

The second sangoma made him breathe in a smoke, and he claims to have seen the ‘twigs’ he coughed out<sup>91</sup>. Bongani does not speculate on the origin of the twig-like things, and how they might have gotten into his chest, indeed he proclaims his shock, as if certain that they did in fact originate from his chest. To all intents and purposes, this account comes across as a case of sleight of hand. A traditional placebo of sorts in which the sangoma, at some point, is likely to have dropped certain things into the bowl in which he directed Bongani to spit.

*B: They [Bongani’s elders] finally let me go back to the clinic at Ma Afrika [Emjindini satellite clinic]. It was then that they did tests and for the first time I learnt that I had TB.*

*They gave me the medication and sent me home, they told me to take it early in the morning. For one, two, three months [Bongani deliberately ticks the months off his fingers as he talks]. I drink the medications and I went for another check-up - for another sputum test, and they said your results are still positive!*

*And the nurse questioned me. [Bongani affects a high pitched voice to dramatise the nurses reaction] You must always take*

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91 In this respect I am reminded of a historical account of a doctor who ‘cured’ a patient whom she considered perfectly well. The patient complained of flies in his chest. When she gave him an expectorant, she tells the story of her gathering some dead flies from the windowsill to deposit in the receptacle in which the patient spat. Upon seeing the fly in the receptacle, the patients discomfort is described as disappearing. See Digby (2006)



*your tablets! Are you drinking your tablets every day? Are you lying? You must tell the truth!*

*And I said yes, **every day**! It was only then that they said that the tablets maybe cannot do anything for you, that maybe you have MDR.*

*MDR? I was thinking what is that? I had never heard of MDR, and it is then I learnt of this thing called multi-drug resistance, which means the drugs they were giving me doesn't work on the body.*

*P: Okay. What happened then?*

*B: They wanted to do a test to see if it was MDR, but they said it was going to take six weeks. And then they said that if I was MDR, they would organise me to go to Witbank [a town with a specialist M/XDR TB facility<sup>92</sup>]. I went home and stayed a week [awaiting test results], but after a week at home, [shakes head] I now felt like I was dying.*

*I had never felt so bad before in my life. I could only sleep the one side, if I tried the other side it was too painful and I just couldn't breathe properly. When I tried to eat, I felt like vomiting the whole time. I couldn't even put something in my mouth.*

*I got my parents to take me back to the clinic and I begged them to do something to help me because I was dying. Straight away they [the nurses at the clinic] said okay, we'll get you into Barberton.*

Bongani repeatedly positions himself as subordinate to his elders and, at this point of the story, he claims to have pleaded with them to be allowed to go to the clinic after the second sangoma's methods ultimately turned out to be ineffective.

His desperate pleading with his elders eventually does lead him back to the clinic, where he finally receives a definitive diagnosis of tuberculosis and is placed on a course of

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92 At the time of our meeting, Barberton TB hospital was not strictly geared up to receive MDRTB patients. Bongani was only one of a handful MDRTB patients resident. This had changed by the phase four, where the hospital had been designated a specialist MDRTB specialist treatment centre.

treatment. He emphasises his months of treatment with a deliberate ticking off on his fingers. And he does it in this instance not only to reinforce the argument running throughout his narrative that he is a responsible drug-adhering patient, but specifically because he is pre-empting the next element of his story as he is relating it to me - the accusation of non-adherence levelled at him by the nurse at Ma Afrika clinic.

Indeed, this is not the last time Bongani expresses dramatic irritation and exasperation at being labelled in this manner. And neither is it solely done to position himself in response to criticism from members of the biomedical community. As I would later learn, there is significant stigma and accusation levelled at MDRTB patients within the hospital by fellow patients with standard drug-sensitive TB. Indeed, those with drug sensitive TB express fear of being in the same facility as MDRTB patients, as they are concerned at the risk of nosocomial transmission<sup>93</sup>.

Even within his current treatment setting, there is a significant emphasis placed on drug adherence, and Bongani wants to convey the impression that he has been adherent at all stages of therapy. His MDRTB status has already been used by nurses to impugn his moral position and integrity. He staunchly positions himself as a responsible adult, and asks me whether it is possible for a person to '*catch MDRTB*'.

In two subsequent meetings, he repeats this question which leads me to think he is still in the process of affirming a narrative-past, one in which his MDRTB is contracted rather than developed. In this respect, I am also a potential source of knowledge - someone who he assumes can lend plausibility and legitimacy to his challenge of the prevailing biomedical attitudes towards him. This particular observation speaks to the narrator-audience relationship I had established with Bongani. His questions is strategic, positioning me as the potential '*expert-audience*'. A positive response from me would lend considerable support in justifying his MDRTB position, as well as vindicating him. This causes no small amount of tension in myself as, until this point, I had purposefully

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93 All PTB patients know from education received during induction into the facility, the dangers of MDRTB. They also know from observations how painful it is to receive treatment, and many express real fear at the thought of contracting the resistant form of disease. MDRTB patients are now separated by a fence, and those inside this enclosure are prevented from wandering into the PTB area by a security guard. They are, as it were, in a prison within a prison. Not permitted into the rest of the grounds that PTB patients have the freedom to wander in.

been trying to position myself as a researcher-as-suppliant<sup>94</sup>, not as an expert (England, 1994).

The conversation eventually heads back towards Bongani's reflection on the different therapeutic narratives he encountered during his journey. At this point he has already expressed scepticism of African traditional medicine, and he tentatively advances on this.

*B: You know the traditional medicine, I don't know, but I'm not so sure it's working. Perhaps I should say in my experience it doesn't work for me.*

*P: Why do you say that?*

*B: Well, you know some people say you have to believe it for it to work, and maybe I am not sure if I believe it.*

*That's why I was thinking that because I believe in God [pause] so when I went to the ZCC I really thought that it might work.*

*But when they said exactly the same thing about the neighbour bewitching me [shakes his head], **hai** [slang: denotes a negative position in this context] I don't think it was my neighbour.*

*This disease, they make it as if you have it because you have enemies. And even for a time I thought I am feeling this because of witchcraft. It feels like someone is attacking my body from inside, and you [I] cannot fight back. So the elders tell us to go to someone who can fight back, like the sangoma.*

*In the end it was TB. [long pause] I now think that it was TB the whole time.*

*P: You went to the doctor first before going to anyone else. You said he told you, you had pneumonia...*

*[Bongani interrupts]*

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<sup>94</sup> The researcher as suppliant role is a description of the power dynamic between interviewer and interviewee, wherein the knowledge and experience of the interviewee is accepted as being greater than that of the interviewer. This is fundamental in the domain of narrative interviews, and features in long standing debates in the public health sciences on lay-expert knowledge. (Popay and Williams, 1996; Prior, 2003)

B: ... Ya [yes], but I don't think he got it wrong. I have been thinking of that, and I went to him and said I had a sore chest. But he didn't ask me about anything else.

*If I had said I have night sweats, and I have problems sleeping, if you say this to the doctor straight away, he's going to say yes, you have TB. If I had told him the first time I saw him, I had cramps, I had night sweats, I couldn't sleep, then maybe I wouldn't spend such a long time trying to cure something at the traditional healers.*

P: You also mention that your elders made a lot of decisions.

B: Ya [yes], because they are my elders, I have to listen to them. I don't have a say. They have this saying, this belief that a sick person is a most dangerous person. That the sickness maybe makes you angry or violent, and makes you behave in strange ways.

*I told them please don't take me to the sangoma, they said no, he will help. They begged me and I thought no, this is my parents and my grandparents. Let me do what they say and maybe they are right.*

*But when it didn't work, when I found out I had TB I didn't say to them see! I told you so! They are just trying. They didn't know just like I didn't know, so I cannot blame them.*

*I thought TB only gets people who smoke cigarettes, and I was so surprised I had found out I got TB because I was not smoking. In my thoughts I was having this idea that people who drink a lot, people who smoke a lot, are the ones that get TB, and that's when I started finding out about TB. I was shocked when I found out!*

This phase of Bongani's story, is less narrative account, and more an extended critical reflection of his meandering journey through various therapeutic avenues. Whereas in the opening acts he comes across as sceptical of the *tangoma* and their diagnostic explanations and therapeutic methods, apart from the latter account in which he genuinely dramatises surprise in having 'coughed up' twigs, he now positions himself very differently. His views on traditional medicine pivot from the more general "I'm not sure

*its working*” to the much more specific caveat “*Perhaps I should say in my experience it doesn’t work for me*”.

Bongani highlights the potential that treatment failure might well be his own fault. An admitted lack of belief in the efficacy of African traditional medicine. This assumption of the responsibility for lack of efficacy lying with him, parallels his explanation of why the ZCCs *indayela* ultimately failed.

A criticism of the ‘traditional’ therapeutic metaphor is clearly evident, with an emphasis on the illness metaphor which was associated with the ‘traditional’ diagnosis. “*This disease, they make it as if you have it because you have enemies. And even for a time I thought I am feeling this because of witchcraft. It feels like someone is attacking my body from inside, and you [I] cannot fight back*”. While Bongani considers this ‘traditional’ metaphor as an apt description of the illness experience, he begins to make a clear distinction between illness as an experience with culturally laden metaphors, and disease as something else.

Bongani glosses over the biomedical establishment’s role at the outset of his narrative, claiming that his chest problem was initially diagnosed as pneumonia. And while in a separate follow up interview he mulls over the possibility that the biomedical establishment potentially misled him by withholding the ‘true’ diagnosis of TB, in this interview, he assumes responsibility for this diagnosis. “*If I had told him the first time I saw him, I had cramps, I had night sweats, I couldn’t sleep, then maybe I wouldn’t spend such a long time trying to cure something at the traditional healers.*” It is around this point that Bongani moves from exploring past narrative, and begins to examine his current state and location.

B: *Every day now in here I get treatment, in the morning and in the night. And I have been in here for nearly six months now, and each month I give another test, but they say I’m not negative yet. [long pause] But you know I was thinking that in here [long pause] its like a contradiction.*

P: *What do you mean a contradiction?*

B: *[long pause] After I started the treatment, after weeks of pain all the time, the pain started going away. The feeling of*

*cramps, the coughing is gone. Before I could only sleep one side, and I came here and I could lie here on the bench in the sun, or under the tree and sleep how I wanted, and I can breathe properly.*

*Before it was like I was losing my strength, feeling very heavy, dragged down. Then I started feeling better for a short time. But only a short time.*

*Eish. [Slang: in this instance, a sardonic expression of bitter irony]. Now I feel I could die every day. Before I could not sleep because I was coughing and could not breathe properly if I slept on one side, now I cannot lie down properly because of the injections. It's too painful. My backside is sore from the injections every morning, and whenever I get them, it makes me very dizzy. Now I feel my joints are weak, and I have to move my body slowly.*

*I can't stand up fast. I must take everything very slowly. And there is this noise in my ears all the time now. Sho [Slang: In this context denoting disappointment, deflation – almost a verbalized heavy-sigh]*

*TB is a painful thing. You know I think even HIV is better because you can treat it, but this one. [Bongani shakes his head in lamentation]*

Bongani provides a quick, somewhat dramatic, summary of his experience in the hospital, describing the paradox of treatment as a 'contradiction'. A description of the initial stage of treatment, in which his symptoms are alleviated, is delivered in a wistful tone layered with loss and regret. He describes the early alleviation of symptoms with an almost dreamlike quality, that his initial phase in the TB hospital was a welcome escape from the grip of a terrible disease. The very fundamentals of existence have been returned. "*I came here and I could lie here on the bench in the sun, or under the tree and sleep how I wanted, and I can breathe properly.*" But this is clearly a segue, a narrative device of a 'too-good-to-be-true' turn of events that indicates to the audience an impending 'fall' is just around the corner.

The subsequent fall is described as a lamentation. MDRTB therapy is a very bitter pill to swallow, and Bongani is struck by the deep irony that the path to health lies through a

deeply painful experience, that in his case includes possible permanent impairment to his hearing. He concludes by making a direct comparison of TB to AIDS, the latter of which he declares preferable. And indeed, he is not the only patient to make this exact observation.

#### **6.3.4 *Nolwazi's narrative***

Nolwazi is twenty one years old and lives in Barberton. Prior to becoming ill with primary, i.e. drug-sensitive, tuberculosis, she commuted daily to the town of Nelspruit where she worked in retail selling clothes. Like Bongani, she claimed to be studying for her senior certificate while working. At the time of our first discussion, she had been in the hospital for approximately two and a half months. While her last sputum test was unfavourable, and thus preventing her from being discharged, she was hopeful that a test in the upcoming weeks would indicate an improvement.

Unlike Bongani, Nolwazi was being treated for drug-sensitive tuberculosis and thus was spared the daily injections of second line treatment MDRTB have to suffer. As a result, her experiences of Barberton tuberculosis hospital were very different from Bongani's. Nolwazi had responded well to treatment, and though she appeared slim, she did not have the haggard and gaunt appearance characteristic of her fellow inpatients.

While most patients walked heavy with boredom and pain, Nolwazi sauntered lightly around the facility. With shoulders back, and a confidence somewhat misplaced in the taciturn environment, she navigated the covered pathways smiling at fellow patients and staff. The story of her illness was certainly not reflected in her posture and gait as it was with Bongani, and, had she not been garbed in the requisite blue uniform, I would have struggled to place her as a member of the hospital's community of afflicted. Indeed, while the uniform garb had the effect of obscuring individuality, Nolwazi attempted to mediate this, setting herself as a patient-apart by donning a contrasting bright pink t-shirt underneath. The flash of vibrant pink made it very easy to spot her amongst the milling blue community.

From a distance, I observed that nurses passed her smiles and greetings as she ambled lightly around the facility. When I later found an opportunity to speak to these nurses, they labelled Nolwazi a model patient who raised no fuss, observed institutional directives, and did not challenge their authority when medication-time came around.

My first impression was that Nolwazi actively differentiated herself from other patients. While most were very critical of life-in-limbo within the tuberculosis hospital, Nolwazi was consistently positive. In our discussions, she consistently rationalised her current situation by framing it as a necessary state of liminality from which she would soon emerge.

I did wonder if her buoyant attitude was a consequence of nearing the end of her treatment, and raised this with certain staff. However, it appears that even during the early stages of her treatment, she had been a compliant and responsible patient who absorbed all the details of her treatment requirements, and presented herself as an active, rather than passive, patient when it came to treatment. This conforms closely to Hydén's 'narrative *about* illness', and Frank's restitution narrative types.

On the surface of this, there appears a slight contradiction to this. Being an active, rather than passive patient, requires one to make the choice to submit to treatment. One is required to be actively-submissive – active with regards to understanding and learning about one's illness and disease, and the responsibilities of the different actors within the biomedical-treatment nexus, and passive with respect to submitting to biomedical authority, and submitting to the 'institutional-narrative'. Nolwazi treaded this line perfectly, and was praised by nurses for consistently following directives, and for being regimental and uncomplaining in taking her medications.

The overwhelming mood within the facility was one of listlessness, and Nolwazi stood out primarily because she exuded a positivity that cut through this depressive mood. To the delight of the occupational therapist and her team, Nolwazi kept herself physically and mentally occupied as much as possible, engaging in whatever activities were available.

Our first one-to-one meeting was held sitting on the grass one mild morning, a few hours before patients would be driven to seek shelter from the oppressive heat, as the sun slowly climbed to spill into the Lowveld valley basin. Unlike the slow, deliberate, and



painful movements of Bongani, Nolwazi was comfortable, relaxed, and smiling. Her narrative differed from Bongani's, and not only because she had primary, rather than MDRTB, but also because she claims not to have traversed the therapeutic landscape for her illness at all, but rather went directly to her family doctor when she started to feel unwell. Her story, however, is no less complex, and her rationale for choosing to limit herself to the biomedical route, is coupled with an outright rejection of African Traditional medicine. This rejection is woven into a complex narrative of her vicarious experience observing her now deceased brother who, on his own quest for healing, decided to pursue various 'traditional' avenues.

While it may initially appear that she conveys two separate narratives, her own, and her brother's, I argue that they represent one connected narrative, where her own illness experience, and the choices made in relation to this, are influenced by her vicarious experience of having observed her now deceased sibling's struggles.

What emerges in both the content and manner of narration are a combination of narrative with respect to Arthur Frank's typologies. Firstly, a classical restitution narrative, and secondly what I call a vicarious chaos narrative. These are discussed in detail in the section that follows.

*N: It all started when I started coughing, I remember I went to the doctor maybe five months ago. I was coughing, and not feeling so good. My mother is a nurse so she said I should go to the doctor, so I went.*

*I remember he [the doctor] didn't speak to me very much. I told him I was coughing, and I was feeling tired. He didn't say very much, but he gave me some pills to take, and he told me to come back if I was still feeling unwell.*

*So of course the pills didn't work, but he didn't really tell me what he thought my problem was. So when I went back to him a few days later and I said to him, I am still coughing, and that I was having trouble sleeping, in particular during the night.*

*I remember every time I tried to lie down to rest or sleep, I would start coughing. My left lung wasn't so good, and it felt*

*like I needed to cough all the time. Sitting up I was fine, but as soon as I lie down... [Nolwazi shakes her head]*

*So I told him I was having trouble sleeping, and about my coughing, and I asked him directly what he thought was wrong with me.*

*I remember he took a few seconds to think. He didn't answer right away, but then he said, I think you have got flu. And I thought you had flu before. So he gave me some more pills, different pills but he changed them all this [second] time.*

*P: Okay, and what happened then?*

*N: I went back to him for a third time, because the doctor stressed [emphasised], he said if you don't see any change with these medications, he said it was very important I come back to him.*

*He never said anything else, but I suspect that he thought then, maybe I have TB. He was suspecting but I think he wanted to make sure by using those other medications to see just in case he was wrong.*

*P: Un-huh.*

*N: Another week passed and I felt I was getting worse. But this time, he looked at me and he said I am going to send you for an x-ray. I want to see what's inside your chest. So I said did he think it was flu, and he said no. He said you cannot be coughing for three weeks, and because of the medication he gave me, if it was flu, he said I would feel better now, so he needed to see the x-ray. So he wrote a letter to refer to me to the clinic.*

*When he got it [the radiograph] back, he showed it to me and he said you have a problem in your lungs here and here [she gestures to her torso].*

*So I said okay, now what? He said Nolwazi, you have got TB. Now we're stopping all the other medications, we're going to send you to SANTA [TB hospital], and we're going to treat you for TB.*

Whereas Bongani's narrative came across as a quest, of seeking understanding, and a therapeutic narrative construct in which he could explain his disordered state, Nolwazi describes a protagonist-self who immediately embraces her state, and the biomedical therapeutic narrative of TB. In passing, Nolwazi mentions that her mother, a nurse, influenced her decision to seek the help of a doctor. However, this is the only time during her entire narrative that she references her mother.

The character of the doctor in Nolwazi's narrative is projected as a combination of hero and knowledgeable sage who, while not perfect – i.e. he misdiagnoses Nolwazi twice before sending her for an x-ray investigation – is nonetheless projected as the person in control. He is projected as a primary character, an advocate recruited to take up arms against the threat to the protagonist's health. Where Bongani describes himself as being subordinate to a therapeutic management group comprising his elders, Nolwazi similarly positions herself as being subordinate, though instead to a therapeutic management group that is recruited by her – in effect her family doctor, and the nurses within the TB hospital.

From Nolwazi's account emerge strong impressions of herself conforming to a Parsonian sick role, and this is reinforced throughout her narrative. The benevolence of the doctor and nurse, the supplication, the suspension of social obligation, and the requirement to conform to the biomedical narrative are all dominant themes in her story.

N: *By listening to that [doctors and nurses treatment directives] that is why I'm like this [improving in health]. And soon I will leave here, but if I didn't listen to that [adhering to treatment guidelines], maybe I would still be the same, and getting worse.*

*I'm not worried about work, I just want to be completely healed. There are some people here, they go to the doctor and say I'm healed just to try and get out early. But I'm not one of them. Of course I want to get out of here! But the doctor has to be the one who can say right, its over, you can go home now.*

*If I didn't stay here, maybe I would be gone - dood mos [Afrikaans: dead then]. Now I have a 1-plus from a 3-plus [a reference to her monthly sputum tests indicating an*

*improvement], that means if I can test maybe next week, or the week after, I can be gone. I'm waiting for the **doctor** to tell me [I can go]. Its not for **me** to tell the doctor so.*

Nolwazi portrays herself as someone who is rigid about obligations, and fully understands her responsibility within the treatment nexus. The initial phase of her account is portrayed briefly with a period of critical reflection, where she compares herself to patients who attempt to assert control over the biomedical therapeutic narrative. “There are some people here, they go to the doctor and say I’m healed just to try and get out early. But I’m not one of them.”

By emphasising this critical comparison, and the positioning of herself, she reinforces the thread of her narrative in which she invests the biomedical system with the responsibility and legitimacy to dictate the terms of treatment and control over her body. Her narrative also emphasises individual and institutional responsibilities, and the requirements of her to conform to the biomedical institutional narrative. The requirements for release back into society pivots on objective indicators, a sputum test that will indicate that she is no longer a danger to society.

It soon emerges that Nolwazi’s narrative account is very different to Bongani’s. Whilst the latter largely keeps to a sequential temporal unfolding of events, building up his narrative from the foundation up, Nolwazi frequently suspends the temporal-arc of her narrative to speak to me directly about her disposition, describing how she feels, and looks healthy. A great deal is invested in the impending release, and the authority placed in the biomedical system to confer that legitimacy. She waits expectantly, in a liminal state, for gatekeepers to graduate her to a state of health. Far more than Bongani, her narrative is forward looking, and with a clear route mapped out ahead of her, and the surrounding health professionals her cartographers and guides.

This initial act of her story, which revolves around the immediate positioning of herself as someone who submits to her therapy, serves as a segue into a narrative ‘flash-back’. Nolwazi begins her narrative frame very close to the present, while the second major act casts us further into the past, to a period many months before her own diagnosis of TB. In

this, she recounts her vicarious experience of accompanying her brother as he traversed the plural landscape.

Upon reaching this stage of her narrative, her demeanour shifted. She was less upbeat, less positive. Her shoulders dropped ever so slightly, and after a few minutes of talking, she motions for us to rise from our seated positions, where she continues the story while we walk the deserted patch of ground that runs the length of the facility's perimeter wall.

N: *I don't go to traditional healers because I think all they want to do is take your money. They don't know anything. [pause]*

*I went to traditional healers many times, but not for myself, I used to go with my brother who has now passed away with AIDS.*

*He was having this pain in his chest, and we went to a traditional healer many times. But I went with him the first time, and I never knew he had AIDS then. He didn't know either I think, but I don't know. The Traditional healers said he had this thing we call in Swazi sidliso<sup>95</sup>.*

P: *Sidliso?*

N: *Yes. I don't know how to explain it well. It's like if you love someone, or if somebody wants to be with me always, they will put some medicine in my food. They call it sidliso.*

P: *The thing they put in your food is called sidliso?*

*[pause]*

N: *I'm not really sure. I think it's the sickness is called sidliso. Or like if I am staying with my boyfriend and he beats me for no reason, the traditional healer can give me something to stop those beatings, and you put it in his food and after that he will*

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95 Rycroft (1982) indicates that the direct translation is poison. However, this is not a definitive or specific term. Usually discussed in the context of witchcraft and malicious behaviour – Linn (2008) defines it as 'poisons that becomes operational when the victim touches them'. Ashforth(2002) discusses it as something that needs to be consumed by the target (see also Barney and Buckingham, 2012), and indeed, the cognate word *kudlisa* means to cause or help to eat (Rycroft, 1981). Niehaus and Jonsson (2005, p. 181) claim that symptoms of *isidliso* are not specific, and could include 'literally anything that affects the lungs, stomach and digestive tract', and that it is an affliction commonly associated with AIDS.

*be kind. But in the end that thing maybe can cause sickness which is sidliso.*

*It tastes nice because I think the sangomas. [pause] I saw them use a stuff like Raja? You know Raja? [a local brand of spice and curry powders] And you cannot say [recognise] that there is something there in your food, because eish [slang: wow] it tastes ntsa [slang: nice / great / amazing].*

*But in the end if you eat it... [pause] But sometimes, you don't [even] have to actually eat it! Sometimes you can just dream of eating the meat!*

*If you just dream of eating the meat, they say something is wrong, somebody is trying to put that thing, that sidliso on you! If you have a bad dream and you say I dream [I was] eating some meat, they will say no stop it! That is sidliso.*

*P: Okay. So your brother was told he had sidliso?*

*N: Yes, and the traditional healer gave him this medicine and said it was to wash his lungs. The healer also gave him herbs and said he needs to take a bath, and put the herbs in the bath and wash with warm water.*

*With the traditional healers, there are those that are healing and there are those that are killing, and you will never know which are which.*

*Its just when you come there, they will tell you your problem. But when they explain to you what you have and how they will treat you, they say: Oh, I have someone who is having the same problem as you, and when I treated him, he was better. I'll treat you the same.*

*That's exactly what happened to my brother. I was with him when the traditional healers said that. He went to three different healers before he went to the clinic, but by that time it was too late. He went to Rob Ferreira [Nelspruit hospital], but it was too late, and he got so thin and died.*

*It was his own fault. He went to the traditional healer because he started to feel ill. He started having pains in his chest, was having cramps, and was losing weight, and the traditional healer said the other one was here, he was like you, but I give him one, two, three [A,B,C], and he survived.*

*But whatever he gave him, it wasn't for the same thing. At the time I didn't know what the traditional healer was doing. The disease it might look similar, like there could be many diseases where you lose weight, but it doesn't mean it's the same.*

*If you finish this [muti], [and] you go and collect another one, but there was no change in the body, The reason is [because] this medicine is not for that sickness!*

*My brother wasted three months, four months drinking that thing. And then he died. But if he take [took] the decision to go to a clinic or go to a doctor, maybe now he'd still be here. And another thing, every time he went there, he collected another bottle.*

*P: Of imbita?*

*N: Yes. And every time you finish it, you go again, and spend another one-two hundred Rand [approx. 9 - 18 GBP]. My brother spent so much money, but he decided to stay with the traditional healers instead of going to the clinic where the medication is free.*

*As time went on, I said to him this is too much. I used to go with him to the traditional healers, and they all said the same things, and they all just gave him a two-litre [a two-litre plastic soft drink bottle refilled with imbita], and took his money.*

*One [sangoma] even said, next time you come the two-lire is three hundred Rand. I never saw any improvement, and I was suspecting something but I never said anything, but then one day he said [to me] he was going to check for HIV.*

*He never told anyone the results came back positive. Even he didn't tell me, because I only found out later, and he say no, its all right [HIV negative]. And he continued to drink those things from the traditional healers.*

*The last time we went to a traditional healer together, he said to him, I now feel powerless. The sangoma just said no, you must continue drinking.*

*The way I see it, the sangomas just don't change [alter their diagnosis / treatment]. I went with my brother maybe ten*

*times, and each time the traditional healer would give him the same thing to drink. Not like when the doctor diagnosed me with TB. I went to the doctor three times, and after the first time when I was not cured, he started to get suspicious. He changed the medications, and after the second time, even more suspicious. By the third time, [he diagnosed] TB.*

*The healer, he says oh, I treated someone like you many times, and then he says oh, the imbita is very expensive because I have to go far to get these ingredients for this medicine, all the way to Maputo.*

The majority of Nolwazi's second act is a scathing indictment of traditional healers. Interestingly, she does not discount the numinous and the esoteric. Nor does she discount the dangers of witchcraft and how it might be recruited to visit illness and misfortune upon someone. She is, however, very critical of the legitimacy of the healing-claims of traditional healers she has encountered while accompanying her brother on his own health-seeking quest. She is particularly critical of traditional healers who try and bolster their credentials by drawing an equivalence between patients, rather than treating patients on an individual basis. She does however admit that traditional healers vary, with "*those that are healing, and those that are killing.*", but emphasises that it is impossible to tell them apart.

As she narrates this part of her story, I am struck by how very different it is from how she began her narrative. Her initial opening sounded calm and collected, with a defined series of events of her own encounter with her family physician. In this second act, when talking about her vicarious experience, there are only few temporal references. In fact much of this act is less about temporal framing of a story, and far more about critical evaluation.

Nolwazi comes across as if she is trying to convey the chaotic experience her brother endured up to his death: his embracing of traditional healing and the claim that his malady was *sidliso*, his growing weakness, his rejection, or in her view a concealment of his HIV status, are all elements of a story in which she played an observational role. In the vein of Frank, I have labelled this a *vicarious-chaos* narrative. That is, the story reflects and conveys the chaos of her brother's experience up until his death. It is also very



obvious that this is artfully juxtaposed against the much briefer narrative of her illness experience. As if she is trying to compare the dramatic encounters between either healing route. This way lies calm, structure, order, and a definitive diagnosis and a lack of drama. That way lies chaos, disorder, economic exploitation, uncertainty, and the very real possibility of death.

Nolwazi expresses open criticism and even disdain for African traditional healers, disclosing that she considers them directly responsible for the death of both her brother and in exactly the same vein, her sister as well. As an observer to her brother's interactions with traditional healers, Nolwazi criticises the 'therapeutic-narratives' provided to her brother, and questions the source of traditional healers' legitimacy. It is at this point that Nolwazi's narrative becomes more animated as she launches further into a criticism of traditional healers by comparing them to Western biomedical practitioners.

*N: And the sangoma's don't see inside you like the doctors. When I got sick, the doctor showed me the x-ray. I could see there what was inside me. The sangoma he said to my brother: did you dream you are eating meat?*

*P: Because he thought he had sidliso?*

*N: Yes! But the doctor will do all these tests, and then they will follow you. My doctor phoned me in here last week, and he asked me if I'm taking my medications properly. He asked me how I was feeling, whether I was feeling better. Because I know he needs to know if I am not feeling well, he needs to change the medications or I will not get better.*

*I don't know where the traditional healer learnt, because I hear that they have got some certificate. Some sangoma what-what-what [dismissive: blah-blah-blah] they call it a name. I'm not sure about that. I know there are schools for them, but where they get the certificate, I don't know. According to my opinion, they must show me something that I can trust. Where is their schools? Where did they learn to mix [medicine]?*

Nolwazi's personal account, when describing her own position and illness, conforms to characteristic of both Weingarten's progressive, and Frank's restitution narrative. This is deeply embodied in her expectations that her healing-trajectory will unfold in a positive, direction, provided she continues to comply with the therapy.

Nolwazi's is a story of incremental improvement, where each pill swallowed, brings her closer to a position of restitution. As Weingarten suggests, these stories of restitution are likely the easiest to listen to, and the easiest to interact and resonate with. These are positive accounts that are forward facing, and indeed, Nolwazi's narrative about her own struggles with TB, are not rear-facing. Compared to the aspects of her story that deal with her brother's experiences, she describes having a relatively easy and painless path towards wellness, relating to both her physical state, but clearly also her mental state.

In the account of her vicarious experiences with her brother, there is a clear and definite emphasis of the physical and mental chaos. By weaving in the account of her brother's experiences, she does not project two separate narratives, but instead she is describing the deep bonds of narrative interdependence. Nolwazi's brother's story is intimately connected with her own, and indeed her vicarious experiences with his own traversing of a therapeutic landscape undoubtedly influenced her own subsequent route. But there is also a great deal more depth to the narrative interdependence that connects Nolwazi and her brother.

While her brother quite obviously would have had his own illness narrative, of which Nolwazi played a significant observational role, I would learn in a follow up discussion that Nolwazi's brother not only had HIV, but also TB. And after disclosing this, Nolwazi ponders whether her own TB infection may in fact have been passed on to her from her brother. Her own narrative is not merely one of striving towards 'health', but doing so in a manner to combat what might be the self-same pathogen that resided in her deceased sibling's chest. Her narrative is not just that of fulfilling a sick role, and to be seen to be actively doing so. Rather, her impetus might well include the need to combat what she suspects in the very same pathogen that originated directly from her brother.

Of interest when Nolwazi was speaking, is that whether wittingly or otherwise, she herself recruited certain meta-narrative characteristics when describing her own account. Upon first impressions, I assumed that a recounting of her vicarious experiences through

her brother, she was in fact expressing certain elements of a chaotic event. And I do not doubt that the declining health of her brother, was a very chaotic period in her own life.

Nolwazi own health-seeking narrative, is certainly related to her vicarious experiences of her brother's chaotic life-end. In creating her own narrative, she was not merely conveying a story, but crafting it by leveraging meta-narrative forms. The responsible adherent protagonist patient, the misguided brother, the antagonist-traditional healers, the knowledgeable sages and saviours in white coats. And of course the antagonistic and life-impinging and existentialist threat.

Bongani's narrative comes across as very different. It is far longer, and describes a much more meandering journey with various characters who are 'pseudo-sages', and encounters with various forms of institutional of knowledge. His own narrative account, however, does not appear to fully be compatible with any notion of Arthur Frank's primary narrative categories. He does not strictly conform to the restitution narrative evoked by Nolwazi, nor Frank's quest narrative, in which the illness is merely one aspect. At one point I did consider whether there was some element of the chaos narrative, but his sequential recollection and framing of his account did not conform to this either.

Bongani's current disposition, in which he finds himself in significant pain, and where there is an ever-present uncertainty as to the future mapping and plotting of his illness, most closely reflects that of Kaethe Weingarten's regressive narrative. This, suggests Weingarten, is the most frightening narrative, characterised by desperation and uncertainty. It is one in which there appears to be a downward slide, where one is not getting better. In her own personal experience of breast cancer, Weingarten describes a feeling of being cast adrift, uncertain of whether she is able to 'hold on'.

Bongani's introduction into the tuberculosis hospital, and his daily encounters with painful MDRTB therapy, initially resulted in an alleviation of symptom. Had we met a few months earlier, he may well have constructed his account as a restitution or progressive narrative. Indeed, he hints as much when he describes a very clear 'apex' moment - an initial phase of symptomatic relief, which was soon thereafter followed by a whole new set of painful symptoms resulting from the TB chemotherapy treatment itself, the acute discomfort of daily injections. Indeed, even staff within the hospital were vocal in their sympathy for Bongani, and the resident occupational therapy nurse describes him,

and his fellow MDRTB afflicted, as '*human pin-cushion*'. There is a dimension of the 'tragic' woven into Bongani's narrative, where healing might well come at a very high cost.

#### **6.4     *The tuberculosis hospital as a site of power and control***

As with the General Hospital, it is challenging to convey a thorough systematic profile of views and attitudes with regards to African traditional medicine and Western biomedicine, amongst the TB Hospital staff and patients. What can be said with some certainty about nurses and patients views towards multiple healing avenues, is that they are eclectic, dynamic, often challenging to elicit, and difficult to comprehensively pin down.

Trying to capture and understand the minute details of individual and collective views on medical pluralism is akin to, if I may be permitted to repurpose an earlier metaphor, unravelling a rough knotted ball of wool. You never quite know where and how threads are connected. And disentangling one line, often results in a convoluted Gordian-knot further down the thread. That said, a surface understanding of this can be achieved and described.

Around half of the patients I spoke to, which included eight narrative interviews, and more than a dozen informant interviews and informal discussions, claimed to have visited a traditional healer immediately prior to seeking help from their local clinic or hospital. Only three patients undertaking narrative interviews claimed never to have used African traditional medicine. All patients spoken to in the TB hospital claimed to be following strict treatment protocols, which included shunning any parallel 'traditional' treatment.

Of the nine nursing staff, all of whom identified as Swazi, all but two were familiar with 'traditional' notions of illness causation, such as the dangers of illness arising from some aspect of ritual-pollution, or the need to protect oneself from the dangers of witchcraft. However, only four nurses disclosed a personal use of African traditional medicine to combat these. Though a contingent of nurses were candid about their own personal beliefs, and personal and circumstantial use of traditional medicine, all said that

traditional healers could in no way treat TB, and all were vehemently opposed to patients using traditional medicines alongside TB chemotherapy.

Like many of their counterparts in the nearby general hospital, nurses claimed to be firmly opposed to the consumption of traditional medicines within the facility, seeing the act of ‘mixing’ treatments, as problematic. And while none of the patients I spoke to disclosed that they were using traditional medicine simultaneously with TB medication, more than half claimed to have witnessed the clandestine use of *imbita* within the hospital grounds.

Nurses emphasise that they often encounter patients who have been presented several interpretations for their illness, with the diagnosis of TB being only the most recent. And despite these patients now receiving TB treatment within the facility, nurses claim that the clandestine use of traditional medicines is clear evidence that patients can not necessarily be trusted when it comes to TB medications, and whether they are truly conforming, or adhering to treatment.

While nurses claim that their role largely revolves around the direct observation of treatment adherence, and the continual promotion of a regimental course of chemotherapy, this role also involves addressing any ambiguities of beliefs about the causes of tuberculosis. A patient identified as using African traditional medicine simultaneously with TB chemotherapy is labelled a risk. Someone not only making poor treatment choices that could interfere with biomedical treatment, but also someone who cannot fully be trusted that they are taking the biomedical intervention entirely seriously.

Indeed, many patients are well aware of this, and some describe the role of nurses as more than mere professionals overseeing the dispensing of medications. For example, Ephraim, a forty year old patient on MDR treatment, mused that the ‘*Direct Observed Treatment*’ protocols they are placed under were not merely a treatment strategy where nurses visually confirm the swallowing of TB pills, but rather that ‘*Direct Observation*’ was tantamount to a much broader ‘policing’ of patient bodies within the hospital’s confining spaces. An exercising of biomedical power that included the attempted quashing of patient attempts at ‘mixing’ traditional and allopathic interventions.

Traditional medicine use within the hospital is present, and clandestine, and characterised by nurses, even those nurses who disclose a personal use of traditional medicines

themselves, as an incursion that is in direct contradiction with TB treatment protocols: an incursion across the physical boundaries of the enclosed and controlled perimeter; an incursion into the notional 'biomedical' space; and, given the object and locus of this control, an incursion into the patient body, and into its internal workings where TB is isolated.

There is also the strong and prevailing notion that hospital patients consider TB to be a disease of disgrace, shame, and stigma, and this is by no means novel. And indeed the relation of this in consideration with the hospital as a site of control, of submission to authority, and enforced therapy, has already been touched upon, and has been raised in classic Goffmanian and Foucaultian style (Gibson, 2004).

As already noted in Chapter Four, Barberton Tuberculosis Hospital is situated on the periphery of the town, lying approximately two kilometres from the town centre. When I negotiated past the guarded and gated entrance for the first time, I found myself in lush verdant surroundings with well-tended flowerbeds. Veranda-wrapped buildings sat rooted amongst mature Jacaranda trees, and the overall atmosphere was one of stillness, order, and calm. However, this 'relaxed' atmosphere within a walled enclosure, was juxtaposed against the occasional glimpse of razor-wire peeking through the branches of the arboreous grounds.

This impression of the hospital as a carcerate facility was further re-enforced by the sight of patients scattered around the grounds uniformed in ill-fitting institutional pale-blue (sometimes pink) pyjamas. Many were also shrouded in serviceable, if threadbare, light blue 'bath-robos' with BARBERTON TUBERCULOSIS HOSPITAL stencilled on the back in one-time red, now wash-worn pink lettering. The impressions of a carcerate institution, however, do not end here.

Upon entering the facility, patients are required to relinquish personal clothing for regulation hospital-wear that though utilitarian, and clinically practical, is austere and depersonalising. This uniform defines the wearer's group affiliation - a membership to a community of affliction and contagion immured under state-sanctioned biomedical control.

The pale-blue uniform stands in stark contrast to the clothing of other 'groups' within the hospital. Nurses in dark-blue dress bearing epaulettes and badges, outward symbols of

professionalism, education, and biomedical authority to exercise power through direct observation and control. Groundskeepers, cleaning staff are dressed in plain serviceable cleaning uniforms and overalls that, though embodying their own symbolism of the wearers interaction with dirt, does not convey the notions of stigma of the TB patient uniform, which I would argue labels that patient as a harbourer of ‘hidden-dirt’, internal-pollution and contagion, dysfunction and indeed social-dislocation.

The pale-blue patient garb defines not only the wearer as part of an afflicted-community – an unproductive, potentially uncooperative patient-body, but a body that is the direct focus of attention of other ‘groups’ within the hospital. While the non-patient uniforms of others in the hospital setting effectively allow a persons to maintain confidentiality of their inner-most intimate health secrets, the patient uniform, stands as a beacon, projecting a leper-like message of ‘uncleanliness’ and ‘affliction’.

De-individualising and stigmatising hospital patient uniforms have previously been likened to uniforms of other ‘state-regulated’ or ‘captured’ bodies – i.e. prisoners or members of the armed forces (Sacks 1986; Helman 1990). Indeed, one cannot help but view the function and form of the tuberculosis facility through a distinctly Foucaultian lens, and drawing similarities between the hospital and the nearby Barberton prison – also sited on the margins of Barberton society.

Both facilities hold immured and uniformed populations who are required to submit to a structured daily routine with rules and regulations defining acceptable behaviour. Both immured populations are required to acknowledge and learn about their ‘dysfunction’ and submit to a period of appropriate corrective-measures following which they might be deemed fit for release into a society where they may no longer pose a threat. Patients are housed in barrack-like buildings separated into ‘blocks’. These blocks are further separated into nurse-stationed Nightingale wards each containing more than a dozen beds spaced roughly one and a half meters apart – and these nurse-stationed wards are broadly, though not entirely analogous to Foucault’s allusion to the Benthamite panopticon. The panopticon comparison in this instance as the ‘observed’ can themselves openly and freely observe those exercising institutional control over their bodies.

Each patient is provided a personal bed space, that effectively functions as a location co-ordinate, *block-x : ward-y : bed-z*. Walking around the facility, the impression I received

was one of an immured patient, effectively de-individualised and institutionalised. These impressions were shared by the hospital's full time occupational therapist:

*I find the patients come in here and they are mixed into the system, and there is very little they can do about it. They come here, or their family puts them here, or they choose to be here, but no one **wants** to be here. But they kind of get shoved into the system, [are compelled to] follow the programme, and it's almost like they become institutionalised. I find it terribly irritating and frustrating.*

*I'm referred a patient, and I go to the wards to find the patient, and I ask the [nursing] staff, 'I'm looking for Mr XYZ', and they look at you like 'huh?' [Carolyn shrugs her shoulders and raises her arms]. And I say it's the man on crutches, or the woman who can't use her arm, and **then** they'll immediately know who it is.*

*Carolyn, Occupational Therapist*

Upon entry to the hospital, patients undergo a phase of 'orientation'. In this phase, patients are taught the basics of TB infection, and the dangers of drug resistant TB that arises from interrupted treatment. Those who already have drug resistant (MDRTB) are instead taught of the dangers of extensive drug resistant TB (XDRTB).

Patients are taught what they can expect over the next three to six months in the hospital, and the subsequent eighteen months of follow-up community-based treatment. The routine and rules of the hospital are made explicit, regulations and prohibitions are explained – specifically no alcohol, dagga (marijuana), or weapons such as sharp instruments or guns are allowed within the facility.

The rules governing *pass-outs* are also covered. Pass-outs are short-term hospital leave, usually a brief period of a few hours during a week day, or a weekend off to visit family, provided they have fulfilled certain 'good behaviour' provisions. These include strict therapeutic adherence, a minimum of a month of uninterrupted treatment.

Though patients are technically permitted to leave the facility for a limited time on a pass-out once a month, many patients interviewed would find this a significant challenge. Those undergoing MDR therapy were suffering significant side effects that include injection site pain, nephrotoxicity, ototoxicity, and nausea. These are not uncommon side effects (de Jager and van Altena 2002; Nathanson et al. 2004; Duggal and Sarkar 2007), and many are debilitating and disorienting enough to render patients unwilling to leave



the facility. During a narrative interview with Nobuhle, a thirty year old mother of two who had been in the facility for four months, she repeatedly drew attention to the painful reality of treatment.

As I sat opposite her, she spoke to me in a hoarse whisper, and was clearly in significant discomfort. She was lying with her legs to one side, partly leaning against a wall, and sitting on a several blankets, each of which were folded several times to make a make-shift cushion. She spoke English haltingly and deliberately, and when she referred to her injection site pain, she cupped her hand and moved it slowly to cradle this painful area. Nobuhle was a prime example a ‘human pin cushion’ alluded to by the hospital’s occupational therapist.

*I have these, what do you call it, bumps? Lumps? I cannot sit down properly anymore for weeks. I sleep on my side. Every time you see me, I’m here. [Nobuhle pats the blanket she was sitting on while on the floor], you see I’m not moving.*

*Nobuhle, MDRTB patient*

The morning of our meeting, Nobuhle had not yet had her kanamycin as the pain in her injection site was said to be unbearable. So much so that one of the nurses mentioned to me in private that Nobuhle had cried at the mere anticipation of the treatment.

To try and work around the pain of treatment that morning, the nurses had attempted to locate a vein in her arm where they might insert a catheter. However, the nurse was not able to locate a vein that morning:

*No veins. I didn’t get any injection. They are waiting for my veins. Is very very painful. We get our treatment every morning and the tablets are so many. You have to take your MDR treatment, and you repeat treatments and you become nauseous all day. The tablets are so many sometimes you just wanted to vomit and vomit. And it hurts! That really hurts.*

*Nobuhle, MDRTB patient*

I was little surprised to discover that the TB hospital has achieved a somewhat stigmatised reputation in wider Barberton society. Informal discussions with a range of staff at the nearby General Hospital indicate that there was a strong disliking of the facility, with a number of nurses having transferred from the Tuberculosis to the General

Hospital for fear of nosocomial / occupation infection. One of the facility's senior manager's stated that it had been known for nurses to be admitted into the facility as patients themselves.

The medical manager of Barberton TB Hospital stated that the institution had over many years attracted the rather unwanted, if dramatic sounding, sobriquet '*the hospital of death*', the appellation referring to a period of roughly a year prior to my visit, when the monthly mortality rate hovered consistently around thirty patients. The rate during my visit, and following the installation of a new medical manager, appears to have been lowered to single figures per month.

Some nurses even opine that the tendency for most patients to go to a traditional healer rather than going directly to a clinic, may have as much to do with the stigma associated with the tuberculosis hospital, and the very real fear of what a diagnosis of TB and subsequent biomedical therapy might entail:

*You know the doctors sometimes they blame the patients for going to the traditional healer that its then [because of this] that the [TB] treatment is delayed, when in actual [in reality], it is the patients who are going there because they know they going to be sent here. So they delay coming here because of the reputation [of the hospital].*

*Nomsa, Senior Nurse*

*I heard rumours about here! I cried. I didn't want to come. I heard rumours SANTA is not good, that if you go there, you will die!*

*Siphiwe, MDRTB patient*

It was initially emphasised several times to me by senior staff that treatment within the facility is entirely voluntary. However, discussions with patients suggest a far more complex reality of how an individual might 'find' their way into the facility.

When I heard that I had MDR TB, I was shocked, just so so so shocked. I was at the Rob Ferreira hospital [Nelspruit – a town roughly 40 m away] and the nurse she just said that I have MDR-TB and that the ambulance will take me home to collect my things. I was shocked. I asked why? She said no, the ambulance will take me home and then it will take me to SANTA. But I went home in the ambulance crying, and I couldn't stop crying, I

locked myself in my bedroom because I didn't want to come here. Everyone knew that when you come here, you die.

The ambulance, they waited for me for hours, and my mother, you know she begged me please to go go go! That I was dangerous to my children, she said 'I don't want you here! You must go... you must go and get healed there, then you can come back'. But this place, I only knew this place as a place where people come to die.

Phumzile, MDR TB patient

Having heard several accounts from patients that together painted a picture that a somewhat less than voluntary route into the TB hospital is not unusual, I approached select management within the facility to discuss this apparent fluid definition of 'voluntary treatment'.

One of the nurses whom I had already previously spoken to, and who wished to remain completely anonymous, disclosed that while everyone was said to enter the facility anonymously, in reality, many patients arrive at the TB hospital in a 'transfer' vehicle from surrounding hospital and clinics.

She emphasises that TB hospital nurses sometimes have to explain to oblivious and confused people that they have been brought to the facility to undergo an extended period of treatment. And that what often happens is that patients are usually persuaded into the facility. In many instances, nurses and hospital management lay much of the blame for the arrival at the facility of patients who are unaware of their impending incarceration to the reluctance of the nearby general hospital and clinic staff to fully explain the steps needed to treat TB within the TB specialist hospital.

One member of the management staff related a recent account in which a patient had arrived at the TB hospital from the nearby general hospital, and while sputum tests and an x-ray had confirmed her infectious state, this had not been communicated to her. The accusation runs that surrounding referral facilities are aware of the stigma of the TB hospital, and have long had to deal with patients who refuse to be transferred. As several staff confirmed in private discussions, referring hospitals sometimes don't provide patients the information for them to make an informed decision merely because it raises

too many complications. Staff at the TB hospital are left to manage the complexity of persuading patients that treatment within the facility is, supposedly, a necessity.

This aspect of my research, along with revelations I allude to in the opening pages of this chapter in which immured MDRTB patients are being denied access to uninterrupted treatment, were some of the more challenging issues to encounter and explore. Whilst certain staff members were sometimes willing to be critical of the hospital, and the provincial health department's poor control over drug supply chain management, none were willing to go on record for fear of reprisal. Indeed, even the small amount of information I have alluded to already is heavily truncated and redacted to protect the identity of certain staff members.

While the above issues are important critical points relating to the hospital, and the provincial health department's approach to treating tuberculosis, they of course do not relate directly towards the issues of African traditional medicine that are at the heart of this thesis. However, they do relate peripherally, as the above describes an exercise of biomedical power. And much like in the previous chapter, how the above biomedical avenue relates to African traditional medicine, is largely in the context of this exercising of biomedical control over patient bodies, particularly with regards to what is, or is not, permitted to be consumed within the facility, and here I refer specifically to African traditional medicines.

Most of the tuberculosis patients interviewed, both the eight undertaking more narrative interviews, as well as more than a dozen informal discussions, claimed to have used traditional medicines prior to coming into the hospital. Regarding the concomitant use of traditional with Western medicines within the hospital grounds, all patients repeated a variant of the phrase, '*it's not good to mix*'. However, many patients I interacted with, along with other hospital staff such as the gardener and cleaners, claimed to have witnessed the clandestine consumption of African traditional medicine within the facility.

*Last week there was a family who came, and the patient was sick in bed, she couldn't walk or do anything, and the family, they took out a two-litre wrapped up in a plastic bag. First when you see it you're gonna think, no its cold-drink [e.g. coca-cola], but then you say [ask yourself] why is it in the plastic bag?*

*It's because its imbita, and here is not like the General Hospital where the family comes and close the curtain around the bed. Here, it's open, and the nurse is right there. But the nurse didn't see it, and she went out, and **that** is when the family took out this two-litre.*

*Patricia - MDR TB Patient*

*I have seen lots of people here drinking imbita, but you know they hide it. Even now if you go and ask someone if they are drinking imbita, they are not going to tell you. Meanwhile, it is hidden, either in their table [bedside cabinet], or maybe the family will bring the medicine in with them.*

*Thobeka – PTB Patient*

*If you want to take imbita, you have to take it as a secret because there's... they [nurses] don't like it. They want you to stay using only their medicines. I saw someone last month, he was drinking imbita but he never used to keep it inside like the others. He saw that a nurse came by and he **knew** that she was going to take it away. He used to keep it outside, under that tree.*

*Vusi - MDRTB Patient*

Patients have developed a number of strategies of concealing traditional medicines from the 'gaze' of biomedical staff, with one patient even going so far as to hide his imbita underneath a paw-paw tree, within the tall weeds growing at its base. Vusi himself took me on a walk through the facility, to show me where he had seen a patient secrete his *imbita* only a few weeks prior.

The paw-paw tree sat in the middle of the hospital-kitchen midden, which was situated behind the kitchen building rear-wall, and the razor-wire topped perimeter fence only a few meters away. In a facility with little privacy, this area was removed from most prying eyes, and it was only by chance that Vusi had come across this patient's clandestine activities. To get to the bottle in the weeds, one needed to navigate through scattered decomposing food waste. This was a thoroughly unpleasant experience that likely contributed to the patient's satisfaction that his traditional medicine would largely remain hidden. This secreting of the *imbita* in a midden of rotting vegetable matter was also somewhat symbolic given that traditional healing is frequently associated with notions of dirt and poor hygiene. Accounts of what occurs if nurses find traditional medicines tend to be similar across the facility

*They're gonna shout at you if they found something like that. They're gonna take it and throw it away, or sometimes they gonna take it and show it to the doctor.'*

*Bandile – MDRTB Patient*

*One of the nurses saw it when a family came to visit, and she stood there, but the family they just poured that imbita into the cup to give to the patient. But she was a new patient and the family didn't know they are not allowed to use the imbita in here.*

*Sho! [slang: an exclamation of surprise] Immediately when they want to give it [imbita] to the patient, the nurse shouts NO NO NO. What is this!*

*The family said, NO, we want to help her, but the nurse said No! [the patient acts out scene, using a high pitched voice for the nurse] Don't mix this medication with this! This is not allowed here! Don't come here with this! We don't want to see this here!*

*Nolwazi – PTB patient*

Patients discover very quickly that there is good deal of benefit in conforming to nursing instructions. Indeed, the privilege of being allowed a pass-out of the facility once a month is predicated on the patient's so called 'good behaviour'. A significant component of this behavioural-carrot is complete adherence to drug treatment.

By conforming entirely to their treatment, patients are able to build up a positive reputation, and for many patients, there is a strong element of the Parsonian sick-role. Many patients, for example, repeat almost by rote some of the important aspects of TB treatment, as if TB education has clearly been a major factor in their induction into the facility. And when opining on issues of medical pluralism and African traditional medicine, many patients are adamant that it is too dangerous to take *imbita* and TB chemotherapy simultaneously. However, these self-same individuals apparently then also observe many of their fellow patients taking traditional medicine and Western medicines simultaneously. And certainly many of these patients who are treading in both therapeutic camps, are seen to leave the facility cured of TB.

Indeed, the narrative interview with the MDRTB Vusi did elicit the usual observation that it was dangerous to take Western and biomedicines simultaneously. However, in an informal discussion a week later, his position had change from one of repeating the expected biomedical view point, to one where he observed that he had seen numerous patients over the period of his four months stay using both African and Western

medicines, and these patients had not fallen ill, but instead had improved in health, and had left the facility cured of TB.

The messages that ‘mixing’ could be dangerous and fatal is a message that is quite obviously seen as mixed in itself. Patients not only describe seeing other patients use traditional medicines, but these traditional medicine-users have gone on to successfully complete their treatment and depart from the hospital. ‘*They say mixing is dangerous... but...*’ was not an infrequent reference heard in formal and informal discussions with patients.

While the behaviour and actions of nurses are seen as absolute i.e. ‘*They want you to stay using only **their** medicines.*’ this inflexibility, coupled with messages of biomedical adherence, and the observations that it is in fact possible to successfully ‘mix’ treatments, leads patients to consider the motives of nurses, and the reasons for their policing role.

Reasons given by the nurses for the discouragement of traditional medicines in the hospital are manifold, though can broadly be seen to fall into several categories, some of which have already been discussed in relation to the General Hospital in the previous chapter.

Firstly, the frequently cited issue of potential toxicity and the negative side-effects of traditional medicines. Included in this is the unnecessary complexity added to the work of the physician and nurse, where they describe traditional medicine potentially interfering with the panoply of potential complications and symptoms that already accompany TB treatment.

Second was the manner in which some nurses framed arguments in the context of professional boundaries, and the need to demonstrate, and prove, therapeutic legitimacy. During an informal discussion with three nurses over a lunch break one afternoon, one of the nurses remarked.

*You know we have to tell them [the patients] not to mix, because if they do and they get better, then they won't know it is us who are curing.*

*Nurse Mpendulo*

This was met with nodding agreement from the other nurses present during this, and was a sentiment expressed across Barberton's other health facilities. And while it may certainly be true that biomedicine can cure tuberculosis, the argument against therapeutic overlap appears to be as much about therapeutic legitimacy, and the need to demonstrate the 'power' of the biomedical avenue, coupled with the maintenance of professional boundaries

### **6.5     *Summation***

The role of the nurse, as seen by many patients, embodies a policing of the patient body, and the subsequent imposition of the 'true' treatment avenue. In response, the hidden consumption of traditional medicine alongside TB chemotherapy, serves not only a means of 'covering bases', but also as a means of projecting an aura of cooperation, not wanting to draw a modicum of suspicion as to the mixing of treatments which would undoubtedly result in greater scrutiny by nurses.

This said, nurses are well aware that many patients are not entirely truthful about the consumption of traditional medicines. What we have in the hospital, is a problem of information asymmetry, which results in a complex dance where some patients actively project a façade of cooperation and adherence, where true intentions and actions are masked, and part of the nursing role is to uncover this asymmetry.

Bongani's narrative account demonstrates the bewildering complexity of choices he faced when meandering through various healing avenues, and indeed this complex journey was also reflected in other accounts I encountered. Nolwazi's personal account might come across as somewhat conformist to biomedical ideology, and indeed Nolwazi, at the time we met, embodied and actively projected classic elements of the Parsonian sick role. However, while we can draw a great deal about personal navigation of therapeutic avenues from either account, what stands out is how Bongani and Nolwazi craft their narrative-selves, and their moral accounting of choices, within their stories.



## ***Chapter 7: Reflection and Conclusions***

At the start of this study I set out to explore medical pluralism in two public hospitals in South Africa, looking specifically at how nurses, doctors, and patients with tuberculosis navigate the intersection of African traditional medicine and Western biomedicine. As the research unfolded these broad aims were further developed to explore: 1. the role of nurses as cultural brokers between the biomedical and the traditional medicine constructs, and 2. the narrative accounts of TB patients as they navigated multiple healing avenues.

The literature review outlined the history of the interface between African traditional medicine and Western biomedicine in South Africa, concluding that much of the existing research has been approached from a decidedly ‘Western’ perspective. I described how frequently mooted ‘collaboration’ between systems largely favours a biomedical perspective where it is assumed that the most appropriate position for traditional healers in ‘modern’ public health, is for them to improve upon their training in order to undertake supportive roles as health-extension workers in primary care provision, and TB and HIV mitigation. The literature review also highlighted the widespread criticism from the biomedical establishment concerning African traditional medicine's ontological and epistemological foundations which emphasise the agency of spiritual and esoteric forces in matters of health and wellbeing. These paradigms contributed to a biomedical view that the usefulness and added value of traditional healing rested on the willingness of practitioners to adopt elements of biomedical principles, ethics and diagnostic methods and to facilitate in creating pathways for patients to access biomedical services. It was also noted that the demise of apartheid has resulted in a resurgence in support for traditional knowledge systems where once critical voices against African traditional medicine are now met with responses from within the highest echelons of government. Indeed, I discuss at length the challenges of this aspect of the study on this very project, where discussing the issue of African traditional medicine within a public institution which projects an image of post-apartheid pluralism, is in itself quite challenging.

In the literature review, I establish that there is little research exploring nurses and doctors views on African traditional medicine within a working biomedical context - i.e. with respect to the overlap of these systems within South Africa's hospital and clinics. Furthermore, I show that the existing research largely ignores a significant issue, specifically that the overwhelming majority of South Africa's nurses and doctors are drawn from the country's Black population. In existing studies, nurses and doctors are typecast as professionals first and foremost - presented as ‘medical’ agents somehow divorced from their upbringing, cultural backgrounds and personal

histories. That is, with only a few exceptions, studies from South Africa's public health domain unwittingly position doctors and nurses as if a process of professional-enculturation, coupled with the strictures of institutional norms and practice, have sanitised them of cultural beliefs that existed prior to the assumption of the professional biomedical mantle. In short, there is a lack of a critical view of the role of these agents as anything *but* nurses and doctors. However, this research demonstrated that South Africa's nurses and doctors are embedded within institutional spaces that are a complex amalgamation of cultural beliefs and practices. And this bricolage of culture and belief is not merely reactively navigated by doctors and nurses, it is proactively created and constantly reproduced in line with a panoply of accepted and expected norms and practices informed not only by professional enculturation and knowledge, but also personal and social identity and cultural background. And as individuals navigate this often-chaotic institutional bricolage of culture and belief, responding to professional identity, institutional and patient-expectations, as well as personal objectives, so emerges the dynamic role of nurses as brokers of culture – individuals who straddle cultural and professional worlds, acting as bridges between modern and traditional, and mediating between these positions.

As a juxtaposition to the paucity of public health research focusing on the views of South African doctors and nurses, I reference the countervailing works of historians and anthropologists, notably Barbee (1986), Digby and Sweet (2002), and Langwick (2008). These authors place front and centre the importance of understanding the cross-cultural positions of nurses, and how they contribute to a complex institutional-culture in Africa where the boundaries of biomedical practice and indigenous beliefs collide. This is at the root of the line of inquiry in my thesis where I explore the role of nurses as cultural brokers.

Additionally this research contributes a new perspective to the literature identifying for the first time in South Africa the narrative accounts of TB patients as they navigate multiple therapeutic avenues. And specifically, there have been no studies exploring TB patients who are confined under long-term care in specialist treatment facilities. This thesis builds upon prevailing knowledge by addressing these gaps.

As already highlighted when discussing data collection, and the emergence of the project in Barberton (chapters 3 and 4), my research topic was seen by participants as a politically, and indeed a racially sensitive undertaking. South African culture had for decades been subordinated by an oppressive openly-racist apartheid regime, and the post-apartheid world in which South Africa's public institutions now exist is one where respect for cultural pluralism and personal beliefs are of paramount importance. I was particularly sensitive to the fact that the exploration of views on African traditional medicine within the hospitals may have created a tension with participants who recognized that they were discussing a sensitive subject encumbered by significant cultural and political baggage. Indeed the manner in which participants responded to the interviews exposed the institutional dynamics, and the interaction and tension between health professionals.

It is evident that some participants saw the opportunity to raise concerns in private about traditional medicine as valuable, as they indicated it was difficult for them to discuss certain issues raised with other colleagues for the fear of criticism – i.e. being labelled as culturally and racially insensitive, and 'disrupting' the working environment. I was aware that some participants were concerned that reflecting on traditional medicine had the potential to threaten the thin veneer of cultural sensitivities that nurses, doctors and patients were trying to negotiate and maintain on a daily basis. Indeed, it was this reluctance by some nurses, as much as the willingness of others, to discuss the issues that illuminated the challenges of culture and institutional cohesion within the hospitals.

This study presents a unique insight into the complex institutional world of two hospitals where there are clear challenges arising from the collision of African traditional medicine and Western biomedicine. The research not only explores medical pluralism, and the powerful, often hidden role of nurses as brokers of culture, but it also seeks to map out the complexity of hospital spaces where a carefully constructed institutional culture exists, and where professionals and patients attempt to negotiate expectations and roles.

Emerging from the research findings is a novel awareness of the way in which nurses and doctors cultivate elaborate professional identities that ostensibly conform to roles deemed acceptable by colleagues, patients, hospital managers, and the public at large. Their constructed roles are often elaborate representations of what they believe such roles *should* entail, and how these conform to the codified institutional rules that embody an agenda for universal equality and respect. At the same time, there is evidence of significant deviations between public expectations, and institutional and colleague expectations on matters of health-care provision as

individuals attempt to manoeuvre through, and mediate these often competing paradigms. The following findings emerged on this important theme:

- While the literature, and indeed the study participants, opine that African traditional medicine remain at the boundaries of the hospital, my research has established that this is in fact not the case. As demonstrated in chapters 5 and 6, African traditional medicine is also a biomedical reality. These two systems articulate in complex fashion and dimensions as suggested by the typology outlined in chapter 5 - i.e. *traditional medicine as pathology; biomedical treatment interruption; and multiple concurrent therapy*. That the hospital spaces can be maintained as inherently 'biomedical' is too simplistic in that it ignores the complex reality of how these systems interact over time and location.
- The codified rules of the hospitals embody an agenda for universal equality and respect as the primary principle. Above all, the respect for cultural and religious pluralism, and the respect for personal belief demanded of all hospital staff belies a complex reality of the collision between African traditional medicine and Western biomedicine within these institutions. Some nurses and doctors see an inherent contradiction between the hospital's codified rules which prioritises cultural pluralism, and how this collides with the specific and far narrower ontological domain of Western biomedicine whose principles are in many respects directly antithetical to plural ontology. This is evidenced by some participants claiming that respect for cultural beliefs sometimes appears to supersede that of matters of life and death. Some also felt it was not possible to uphold this primary principle when harm is done to minors under the rubric of 'cultural belief'.
- The challenges of navigating an institution where culture and politics collide is not a simple task. Nurses in the general hospital who are suspicious of, and resistant to, African traditional medicine claimed in private that they do not feel able to fully articulate their frustrations about the collision of therapeutic practices. While the institution embodies a culture of respect for personal beliefs, this institutional code is also interpreted by some as stifling. It is often seen as a root of the challenge of navigating complex institutional-expectations, and expectations of colleagues. To openly criticise traditional medicine and culture risked sanction. Indeed, the only significant criticism about African traditional medicine aired in a public forum was from a doctor. And that she felt capable of voicing her concerns publicly attests a

great deal to the power hierarchies and imbalances that exist between doctors and nurses.

- Some of the health professionals disclosed a personal use of, and belief in the ontological foundations of African traditional medicine and other healing avenues, and attempt to reconcile any contradictions with their own professional practice by clearly delineating between 'Western' and 'African' afflictions and methods of healing. In this respect, many nurses disclose a belief in, and advocate an importance in African traditional medicine in addressing health needs of the community beyond biomedical ken. Furthermore, these nurses clearly position themselves as modern health professional whose healing skills do *not* require engagement with, or propitiation to, the esoteric.
- Nurses disclosing a belief in African traditional also consider biomedical diagnostic tests to be capable of helping African traditional healers by effectively providing a means of diagnostic exclusion of maladies of a medical nature. In this respect they urge the community to seek biomedical help *before* resorting to traditional healers. Whilst many nurses clearly embrace African traditional medicine, the message imparted is that Western biomedicine should be the primary port of call when illness befalls an individual. It is not unconsidered that such a position has been espoused because it is the official position that biomedical practitioners are supposed to convey when talking to a researcher about matters of public health.
- All participants believed that the boundaries of the hospital space need to be respected by patients, and indeed colleagues, as being a *biomedical* space. That is, there should be no overlap of treatment, or *mixing* to use the colloquial. Nurses, regardless of whether they embraced African traditional cosmology or not, consider this an extremely important point. Overlapping therapies leads to 'noise' in the biomedical diagnostic and therapeutic undertaking. This was an issue in both the TB hospital and the general hospital - in which the maternity and paediatric wards in the latter are particular areas of concern.
- Nurses describe patients as being manipulated by traditional healers, whereby healers try and establish an unofficial collaborative chain between the biomedical domain, the patient, and themselves. This is often described as manipulative as nurses complain of patients arriving at the general hospital with specific directives

from the treating traditional healer. Such directives include a 'traditional' diagnosis that the patient has *'low blood'* and needs a blood transfusion, to specific guidance to patients that while they may get treatment from the hospital, they are not permitted any biomedical intervention in which the skin is pierced with a needle. Nurses interpret these directives as a means by which traditional healers maintain sway over patients, thus feeding into the widespread criticism that patients are merely a commodity for unscrupulous healers.

- Participants believe that patients should be free to follow any therapeutic avenue they prefer, however, boundaries of therapeutic practice should be separate, and maintained. Boundaries and spaces of the TB hospital are actively policed and maintained by nurses, and the boundaries of this institution are particularly definitive, demarcated with razor wire, high walls, an entry controlled by uniformed guards. Those patients found with traditional medicines will have them confiscated, and the hospital boundaries are also governed by rules of expected behaviour that the immured population are required to conform to. In this respect, the TB hospital resembles a guarded, gated, and policed prison.
- Nurses within the tuberculosis hospital appear to exert a great deal more power and influence within a strictly controlled environment – this is in contrast to the general hospital whose boundaries are far more porous, and where there is no patient-confinement. In this respect, the detectable diagnosable nature of TB, and the function of the specialist facility to treat a single pathology, meant that there is far less ambiguity about the reasons for the patient's illness than in a general hospital. Whilst doctors and patients attending the general hospital might struggle with the inherent ambiguities of diagnosis and treatment, inevitably arising to speculation about alternative healing avenues, this is not the case in the TB hospital. However, this does not mean that the boundaries of the TB hospital are completely secure, as it is evident that traditional medicine do manage to find their way in to the institution. However, patients consume these clandestinely, and actively hide this consumption.
- TB patients have to conform to expected institutional behaviour and regulation treatment which essentially requires them to cultivate a patient-role. This role includes conformity to rules and regulations; a submission to an often painful treatment regime (for those on MDR-TB treatment). Successful TB treatment

emphasises individual behaviour and adherence to a strict regimen. For those patients also wishing to consume traditional medicines within the TB hospital confines, this means cultivating a role to navigate institutional strictures without betraying that the strict treatment protocols are not being followed.

- The brokering role of nurses which emerged as a significant line of inquiry, examined the notion that nurses act as both cultural and linguistic bridges between patients and doctors, the majority of the latter being unable to communicate through the language barrier. The role of the nurse as cultural broker often emphasises the challenges of acting as a cultural bridge. It is seen as a proactive role in which nurses are the lynchpin, the link between modern and ‘traditional’ worlds, where being positioned at the nexus of cultures, is seen to be immensely valuable.

This is not a value neutral role, however, and the role of nurses as cultural broker is often portrayed as one in which the health professional assists patients to navigate the biomedical domain, and the clinician to effectively navigate *around* (not directly with) the domain of indigenous belief and culture. The nursing role from this perspective still appears to be that of a subordinate to the doctor.

- It was clear that in some instances, nurses project a very clear and dominant biomedical view, and in other instances, particularly if there is ambiguity surrounding the diagnosis, they might come across as more flexible, and indeed negotiable. In some instances clandestinely suggesting to patients that they pursue a ‘different’ healing option ‘outside the hospital’ - which is a euphemism for ‘go see a traditional healer.’
- I would like to suggest that the role of nurse as cultural broker is far more complex, and not merely an act of cultural and linguistic translation. Indeed, the brokering role can be seen as contributing to, and maintaining the boundaries of practice. The role is not merely a means of helping others to navigate the complex collision of cultures, but the role is as much about helping the nurse to manage and establish her own position. This involves protecting and developing his or her own professional identity in a manner that conforms to professional expectations – i.e. what colleagues, especially doctors and senior colleagues expect, as well as aligning these with community and patient expectations.
- The role of nurse as cultural broker is not really part of the official institutional paradigm, though it is certainly acknowledged unofficially as pivotal. Doctors

described the role of nurse as bridges to patients, noting how they acted as cultural and linguistic interpreters for the benefit of biomedicine. They also described nursing colleagues as efficient and professional, and believed that any 'non-biomedical' views, such as the more esoteric elements of African ontology and cosmology did not influenced their work as professional nurses. Doctors believed that it was the training and education in biomedicine that underpinned and shaped, and indeed changed, their nursing colleagues' world-views from previously held 'traditional' views.

- Whilst nurses are recruited by doctors to sensitively communicate on matters of African traditional medicine, there is little in the way of communication between doctors and nurses about traditional medicines itself. No doctors interviewed knew the colloquial terms for commonly encountered traditional illness concepts, interventions or medications - i.e. *masheshisa*, *isihlambezo*, *tindzaka*, '*elevenes*'. This was surprising as it would take little effort to discuss these with knowledgeable nurses when symptoms were encountered in patients. It implies that there is very little communication on traditional healing matters, further suggesting that doctors do not feel the need to explore traditional concepts and interventions when encountered. This also suggests that nurses do not feel compelled to help guide doctors. This was confirmed when in the interviews it was clear that though the nurses knew that a prominent member of the hospital's maternity ward was also a traditional healer, none of the doctors were aware this was the case.
- From the perspective of the nurses in the TB hospital, the role of cultural broker situates them at a cultural nexus. It is a role that needs to be leveraged not only to help diverse groups, but also to manage varying and sometimes competing expectations. This is not necessarily a role that bridges actors in the treatment nexus, but one which is employed to manage expectations, and importantly to project and maintain a professional identity. The brokering role is a useful, and probably the only way for nurses to cultivate and protect a professional identity which is paramount for effectively navigating the institutional world.



### ***Research implication and suggestions for future research***

The findings of this thesis have a number of significant implications for both public health research and provision in South Africa. It is surprising that up until now, the views of South Africa's health professionals have only been marginally explored on the interface between African traditional medicine and Western biomedicine. Importantly, this research has uncovered a little-explored institutional world in South African hospitals, one in which health professionals have to navigate the collision between African traditional medicine and Western biomedicine. It would be beneficial on many fronts to obtain a much deeper understanding of this social and cultural phenomenon as historical apartheid repression recedes further into the past. Potential research-lines that stems directly from this thesis include:

- A clear and present need to better understand the interface between African traditional medicine and Western biomedicine in South Africa, coupled with a more nuanced understanding on the implications of a post-apartheid political dispensation that has vaulted a once repressed African philosophy and traditional knowledge into a place of political prominence.
- Little research has been done to explore how different healing cultures interact within a biomedical setting, nor has there been a great deal of research examining the expectations and roles of individual actors in this nexus. The notion of the hospital as a defined biomedical space needs to be rigorously examined – as it is clear that institutions are not merely established based on strict ontological principles and practices, but instead are arenas for the confluence of healing ideologies, and political and cultural manoeuvring. Importantly, we need to further explore the consequences, both positive and negative, of this on pressing public health matters such as TB and HIV mitigation and control.
- Further research into the role of nurses as cultural brokers in South Africa needs to be revived, and used as a starting point to further understand the overlapping professional, social, and cultural domains that nurses traverse. Further research needs to be undertaken to understand the dynamic nature of this role and the implications for public health provision.
- Whilst this project has taken an ethnographic approach, there would be significant benefit in conducting research that moves towards enumerating the burden of the illness resulting from African traditional medicine. Furthermore, a more

transparent recording of the burden of illness resulting from the negative impact of biomedicine would also be useful.

- Whilst directly observed treatment therapy remains the only successful means of addressing TB, it is clear that the environment and treatment avenues in confining institutions are considered by patients to be inappropriate, oppressive – where treatment within the TB hospital has been considered by some patients to be akin to punitive incarceration. South Africa has numerous TB hospitals that resemble the confining facility in Barberton. The current approach to TB treatment needs to be further understood and addressed to see if a call for community-based observed treatment for all forms of TB, might be more appropriate and indeed beneficial as suggested by numerous TB experts (see Heller, 2010; Brust *et al*, 2012)
- Evidence from this thesis points to potentially alarming ethical issues arising from confined treatment, specifically the break-down of supply chain management for essential second-line TB medications. While this emerged as a peripheral issue to the overall thesis aims, the seriousness of this finding warrants in-depth research as to the extent of this problem, the moral and ethical challenges this raises, as well as the potential impact this might be having on the exacerbation of the TB epidemic through unwitting nosocomial drug resistance resulting from interrupted therapy.
- Public health research, while a multi-disciplinary domain, has yet to draw significantly upon the works and research methods of the social sciences such as sociology and anthropology. There is significant evidence to suggest that these disciplines have a great deal to contribute to the exploration of the interface between African traditional medicine and Western biomedicine.

The above are applicable to the specific locations of Barberton's hospitals, but they are also broad enough to be considered avenues of potential research that are relevant to many of South Africa's public hospitals.

### ***Study limitations***

Reflections of the study limitations, and associated actions and avenues to mitigate / overcome these, have been threaded throughout the thesis-body. The more prominent study limitations include the following:

- My presence in the hospital was under the auspices of the Mpumalanga provincial

government through whom I was required to obtain official approval to carry out the study. I had to provide evidence of this official approval prior to any interview so that staff could verify my credentials. However, my study also recently coincided with significant political friction, and public sector strikes against the self-same provincial government. As a result, stating my presence was under the direct auspices of the provincial government meant that participants, particularly nurses who formed the bulk of the public sector strikes, were highly suspicious of my presence. In the early stages of data collection (phase 2) I was sometimes challenged by nurses to disclose the ‘real’ intent with my research, as if my stated intent of exploring medical pluralism was a poorly conceived front. It took significant and sensitive discussions with nurses, and establishing channels with informants, to convince many that my interests revolved around the stated research topic, and that my connection to the government was merely a necessary hurdle in the research undertaking.

- It was a significant challenge to undertake research on a sensitive matter of culture when I myself am a White researcher who is clearly the beneficiary of a privileged up-bringing that, in part, derives from an apartheid construct. Whilst this did not result in open antagonism, my position as a White researcher meant that participants would respond to me based upon perceived roles and expectations. I can only speculate as to how a Black researcher from the self-same community may have interacted in the same setting. They would certainly not have to overcome numerous cultural barriers to carry out the project. Specifically, they would likely have not had to continue exploring the meaning of certain ‘Africa’ illnesses, how these shape perceptions and behaviours, and subsequently lead to certain interaction within the clinical setting. Furthermore, a local Black researcher might not have been looked upon as an outsider who is effectively placing the ‘Black’ philosophy and ideology under a microscope. I often felt uncomfortable in the research process, as I myself was keen not to be perceived as a *‘White man studying the native’*. Given South Africa’s colonial history, this was a very real and challenging issue to navigate the environment without coming across as overly patronising. My approach at mitigating this was to come across as a supplicant, emphasising the that I was there to learn, as much as I was to research. This also mean that I needed to ensure I maintained a respectful tone when discussing issues such as indigenous ontologies when they clearly uncomfortably collided with my own belief system.
- This is an interpretive ethnographic study rooted in the social sciences. This study is

limited in that it was not possible to enumerate the burden of illness arising from the collision of healing cultures. I make this point with specific reference to the typology of hospital encounters with African traditional medicine in the general hospital – i.e. *traditional medicine as pathology; biomedical treatment interruption; and multiple concurrent therapy*. While these are frequently referred to by nurses and doctors, there is no defined reporting / recording system within the hospital to ensure this data is collected, and even if there was such a system, the ambiguities of overlapping treatment, where patients often hide their traditional medicine treatment, means this would be a significant challenge to overcome.

- My own proclivities lie towards Western biomedicine. Holding a worldview that is shaped by a deep and abiding affiliation to a rational scientific paradigm meant that I was frequently challenged, and indeed often confused when discussing issues of traditional medicine. Discussing African beliefs which evoke ontological paradigms in which the numinous and esoteric command sway over matters of health, illness, but also general living, meant that I was constantly challenging my own interpretive lens. But this also mean that I was framing novel perspectives by extrapolating the consequences of such view points into my own paradigm of thinking. In particular, I would frequently find myself discussing African ontology, and subsequently the ethics of African traditional medicine though a lens of a transposed and dominant Western-oriented ethical framework. There were clearly harmful implications on the use of African traditional medicine on minors – and also adults who felt compelled to take these due to familial and social pressures. This is not to say that a Western-oriented lens is not sufficiently equipped and nuanced to frame the ethical conundrums that result from African traditional medicine use, however, it must be recognised that it is challenging to impose this ethical framework in such a context, as it is clearly perceived to be aligned to hegemonic colonial ideology in which biomedical knowledge and principles are considered superordinate.

To conclude, this research presents a challenging, but a crucially important contribution to a number of issues regarding the confluence of medical cultures in South Africa; the challenges of institutionally-confined TB therapy, and the role of nurses as brokers of culture.

## *References*

- Aker, J.C., Mbiti, I.M., 2010. Mobile Phones and Economic Development in Africa. Social Science Research Network.
- Andreadis, P., 2007. Traditional healers in Ixopo, Kwazulu- Natal, South Africa: Cultural concepts of illness and perceptions of Western Biomedicine. Implications for collaboration and public health. MSc Public Health Research dissertation. University of Edinburgh.
- Ashforth, A., 2002. An Epidemic of Witchcraft? The Implications of AIDS for the Post-Apartheid State. *African Studies* 61, 121–143.
- Ashforth, A., 2005. Muthi, Medicine and Witchcraft: Regulating “African Science” in Post-Apartheid South Africa? *Social Dynamics* 31, 211–242.
- Ashforth, A., Nattrass, N., 2005. Ambiguities of “Culture” and the Antiretroviral Rollout in South Africa. *Social Dynamics* 31, 285–303.
- Bailey, C.A., 1992. A Guide to Field Research. Pine Forge Press.
- Barbee, E.L., 1987. Tensions in the Brokerage Role Nurses in Botswana. *Western Journal of Nursing Research* 9, 244–256.
- Barberton Hospital, 1985. Barberton Hospital/Hospitaal: 1884 - 1984, 100 Years Commemorative Edition/100 Jaar Gedenkuitgawe.
- Bardien, S., Jong, G. de, Schaaf, H.S., Harris, T., Fagan, J., Petersen, L., 2009. Aminoglycoside-induced hearing loss: South Africans at risk. *South African Medical Journal* 99, 440–441.
- Barker, R.D., Millard, F.J.C., Malatsi, J., Mkoana, L., Ngoatwana, T., Agarawal, S., de Valliere, S., 2006. Traditional healers, treatment delay, performance status and death from TB in rural South Africa. *The International Journal of Tuberculosis and Lung Disease* 10, 670–675.
- Barney, R.J., Buckingham, S.L., 2012. HIV/AIDS and Spirituality in a South African Township: A Qualitative Study. *Journal of Religion & Spirituality in Social Work: Social Thought* 31, 51–66.

- Basu, S., Andrews, J.R., Poolman, E.M., Gandhi, N.R., Shah, N.S., Moll, A., Moodley, P., Galvani, A.P., 2007. Prevention of nosocomial transmission of extensively drug-resistant tuberculosis in rural South African district hospitals: an epidemiological modelling study. *The Lancet* 370, 1500–1507.
- Bateman, C., 2006. Taking ubhejane by the horn(s). *South African Medical Journal*.
- Becker, H.S., 1986. *Writing for Social Scientists: How to Start and Finish Your Thesis, Book, Or Article*. University of Chicago Press.
- Bekker, L.-G., 2008. Trials and tribulations. *Southern African Journal of HIV Medicine* 7, 7.
- Benatar, D., 2010. Just Admissions: South African Universities and the Question of Racial Preference. *South African Journal of Higher Education* 24, 258–267.
- Bongmba, E.K., 2004. Reflections on Thabo Mbeki's African Renaissance. *Journal of Southern African Studies* 30, 291–316.
- Bowling, A., 2005. *Research Methods in Health: Investigating Health and Health Services*. McGraw-Hill International.
- Boyatzis RE (1998) *Transforming Qualitative Information: Thematic Analysis and Code Development*, Sage Publications
- Brown, B.B., 1987. Facing the “black peril”: the politics of population control in South Africa. *Journal of Southern African Studies* 13, 256–273.
- Brust, J.C.M., Lygizos, M., Chaiyachati, K., Scott, M., van der Merwe, T.L., Moll, A.P., Li, X., Loveday, M., Bamber, S.A., Laloo, U.G., Friedland, G.H., Shah, N.S., Gandhi, N.R., 2011. Culture Conversion Among HIV Co-Infected Multidrug-Resistant Tuberculosis Patients in Tugela Ferry, South Africa. *PLoS ONE* 6, e15841.
- Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., Flisher, A.J., 2010. Collaboration Between Traditional Practitioners and Primary Health Care Staff in South Africa: Developing a Workable Partnership for Community Mental Health Services. *Transcultural Psychiatry* 47, 610–628.
- Cassell, J., 1988. The relationship of observer to observed when studying up. *Studies in qualitative methodology* 1, 89–108.
- Chipfakacha, V., 1997. STD/HIV/AIDS knowledge, beliefs and practices of traditional healers in Botswana. *AIDS Care* 9, 417–425.
- CHMT, 2008. *AIDS Charlatan Zeblon Gwalal Exposed - Community Health Media Trust*.

- Clark, S.J., Collinson, M.A., Kahn, K., Drullinger, K., Tollman, S.M., 2007. Returning home to die: Circular labour migration and mortality in South Africa 1. *Scandinavian Journal of Public Health* 35, 35–44.
- Colvin, M., Barrera, L., Grimwade, K., Armstrong, D., Wilkinson, D., 2003. Contribution of traditional healers to a rural tuberculosis control programme in Hlabisa, South Africa. *The International Journal of Tuberculosis and Lung Disease* 7, S86–S91.
- Cook, C., 2009. Sangomas: problem or solution for South Africa's health care system. *Journal of the National Medical Association* 101, 261–265.
- Cullinan, K., 2006. Health officials promote untested uBhejane. *Health-e*.
- Cumes, D., 2013. South African Indigenous Healing: How It Works. *Explore: The Journal of Science and Healing* 9, 58–65.
- Devenish, A., 2005. Negotiating Healing: Understanding the Dynamics amongst Traditional Healers in Kwazulu-Natal as they Engage with Professionalisation. *Social Dynamics* 31, 243–284.
- Digby, A., 2006. Diversity And Division in Medicine: Health Care in South Africa from the 1800s. Peter Lang.
- Digby, A., Sweet, H., 2002. Nurses as Culture Brokers in Twentieth century South Africa, in: Waltraud, E. (Ed.), *Plural Medicine, Tradition and Modernity 1800–2000*. pp. 113 – 129.
- Dong, K., Thabethe, Z., Hurtado, R., Sibaya, T., Dlwati, H., Walker, B., Wilson, D., 2007. Challenges to the Success of HIV and Tuberculosis Care and Treatment in the Public Health Sector in South Africa. *The Journal of Infectious Diseases* 196, S491–S496.
- Douglas, P.M., 1966. *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. Routledge.
- Duggal, P., Sarkar, M., 2007. Audiologic monitoring of multi-drug resistant tuberculosis patients on aminoglycoside treatment with long term follow-up. *BMC Ear, Nose and Throat Disorders* 7, 5.
- Dugger, C.W., 2010. University of Cape Town Sees Affirmative Action Rift. *The New York Times*.
- Edginton, M., 1999. Tuberculosis patient care decentralised to district clinics with community-based directly observed treatment in a rural district of South Africa. *The International Journal of Tuberculosis and Lung Disease* 3, 445–450.

- Edginton, M., Sekatane, C., Goldstein, S., 2002. Patients' beliefs: do they affect tuberculosis control? A study in a rural district of South Africa. *The International Journal of Tuberculosis and Lung Disease* 6, 1075–1082.
- Elliot, E., 2005. , in: *Using Narrative in Social Research: Qualitative and Quantitative Approaches*. SAGE.
- Elliott, J., 2005. *Using Narrative in Social Research: Qualitative and Quantitative Approaches*. SAGE.
- Ellis, D.C., 1996. Ukufa KwaBantu. *South African Family Practice* 17.
- England, K.V.L., 1994. Getting Personal: Reflexivity, Positionality, and Feminist Research. *The Professional Geographer* 46, 80–89.
- Erskine, S.V.W., 1869. *Journey of Exploration to the Mouth of the River Limpopo*.
- Fassin, D., 2007. *When Bodies Remember: Experiences and Politics of AIDS in South Africa*. University of California Press.
- Feierman, S., Janzen, J.M., 1992. *The Social Basis of Health and Healing in Africa*. University of California Press.
- Frank, A.W., 1994. Reclaiming an Orphan Genre: The First-Person Narrative of Illness. *Literature and Medicine* 13, 1–21.
- Frank, A.W., 1995. *The Wounded Storyteller: Body, Illness, and Ethics*. University of Chicago Press.
- Gabashane, M., 2009. Mpumalanga Health on cholera outbreak [WWW Document]. URL (accessed 10.10.12).
- Geffen, N., 2010. *Debunking Delusions: The Inside Story of the Treatment Action Campaign*. Jacana Media.
- Gibson, D., 2004. The gaps in the gaze in South African hospitals. *Social Science & Medicine* 59, 2013–2024.
- Giliomee, H., Mbenga, B.K., 2007. *New History of South Africa*. Tafelberg, Cape Town.
- Gobo, G., 2008. *Doing ethnography*. SAGE.
- Goffman, E., 1959. *The presentation of self in everyday life*. Doubleday.
- Goldacre, B., 2008. *Bad Science*. HarperCollins UK.



- Golooba-Mutebi, F., 2005. Witchcraft, Social Cohesion and Participation in a South African Village. *Development and Change* 36, 937–958.
- Golooba-Mutebi, F., Tollman S. M., 2007. Shopping for Health: Affliction and Response in a South African Village. *African Sociological Review* 11, 64–79.
- Good, B.J., 1994. *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge University Press.
- Gort, E., 1989. Changing traditional medicine in rural Swaziland: The effects of the global system. *Social Science & Medicine* 29, 1099–1104.
- Green, E.C., 1985. Traditional healers, mothers and childhood diarrheal disease in Swaziland: The interface of anthropology and health education. *Social Science & Medicine* 20, 277–285.
- Green, E.C., Makhubu, L., 1984. Traditional healers in Swaziland: Toward improved cooperation between the traditional and modern health sectors. *Social Science & Medicine* 18, 1071–1079.
- Green, E.C., Zokwe, B., Dupree, J.D., 1995. The experience of an AIDS prevention program focused on South African traditional healers. *Social Science & Medicine* 40, 503–515.
- Greene, J.A., 2004. 2002 Roy Porter Memorial Prize Essay Therapeutic Infidelities: “Noncompliance” Enters the Medical Literature, 1955–1975. *Social History of Medicine* 17, 327–343.
- Grobbelaar, R., 2011. Medical schools’ race bar. [WWW Document]. URL <http://www.timeslive.co.za/local/article1074586.ece/Medical-schools-race-bar> (accessed 5.2.13).
- Hahn, R.A., Gaines, A.D., 1984. *Physicians of Western Medicine: Anthropological Approaches to Theory and Practice*. Springer.
- Hahn, R.A., Kleinman, A., 1983. Biomedical Practice and Anthropological Theory: Frameworks and Directions. *Annual Review of Anthropology* 12, 305–333.
- Hall, S., du Gay, P., 1996. *Questions of Cultural Identity*. SAGE.
- Hammersley, M., Atkinson, P., 1983. *Ethnography: Principles and Practice*. Taylor & Francis.
- Hammond-Tooke, W.D., 2002. The Uniqueness of Nguni Mediumistic Divination in Southern Africa. *Africa* 72, 277–292.
- Haram, L., 1991. Tswana medicine in interaction with biomedicine. *Social Science & Medicine* 33, 167–175.

Harper, I., 2010. Extreme condition, extreme measures? Compliance, drug resistance, and the control of tuberculosis. *Anthropology & Medicine* 17, 201–214.

Heller, T., Lessells, R.J., Wallrauch, C.G., Bärnighausen, T., Cooke, G.S., Mhlongo, L., Master, I., Newell, M.L., 2010. Community-based treatment for multidrug-resistant tuberculosis in rural KwaZulu-Natal, South Africa. *The International Journal of Tuberculosis and Lung Disease* 14, 420–426.

Hobsbawm, E., Ranger, T., 2012. *The Invention of Tradition*. Cambridge University Press.

Homsy, J., King, R., Balaba, D., Kabatesi, D., 2004. Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa. *AIDS* 18, 1723–1725.

Horrell, G., 2009. White lies, white truth. *Scrutiny* 14, 59–71.

Hosegood, V., McGrath, N., Herbst, K., Timus, I.M., 2004. The impact of adult mortality on household dissolution and migration in rural South Africa. *AIDS* 18, 1585–1590.

Hydén, L., 1997. Illness and narrative. *Sociology of Health & Illness* 19, 48–69.

Ingleton (

Illich, I., 1975. *Medical nemesis: the expropriation of health*. Calder & Boyars.

Illich, I., 2003. Medical nemesis. *J Epidemiol Community Health* 57, 919–922.

Janzen, J.M., 1987. Therapy management: concept, reality, process. *Medical anthropology quarterly* 1, 68–84.

Janzen, J.M., 1995. Self-Presentation and Common Cultural Structures in Ngoma Rituals of Southern Africa. *Journal of Religion in Africa* 25, 141–162.

Janzen, J.M., Arkininstall, W., 1982. *The Quest for Therapy: Medical Pluralism in Lower Zaire*. University of California Press.

Jezewski, M., 1990. Culture Brokering in Migrant Farmworker Health Care. *Western Journal of Nursing Research* 12, 497–513.

Jezewski, M., 1993. Culture brokering as a model for advocacy. *Nursing and Health* 14, 78–85.

Jezewski, M., 1995. Evolution of a grounded theory: Conflict resolution through culture brikering. *Advances in Nursing Science* 17, 14–30.

- Jezewski, M., Stonik, P., 2001. The Rehabilitation Service Provide as Culture Broker: Providing Culturally Competent Services to Foreign Born Persons. Center for International Rehabilitation Research Information and Exchange.
- Kale, R., 1995. South Africa's Health: Traditional healers in South Africa: a parallel health care system. *British Medical Journal* 310, 1182–1185.
- Karim, Q.A., Karim, S.S., Soldan, K., Zondi, M., 1995. Reducing the risk of HIV infection among South African sex workers: socioeconomic and gender barriers. *American Journal of Public Health* 85, 1521–1525.
- Katon, W., Kleinman, A., 1980. Doctor-patient negotiation and other social science strategies in patient care, cited In Eisenberg L and Kleinman A (Eds.) *The relevance of social science for medicine*. D Reidel Publishing, Dordrecht , Holland.
- King, R., Homsy, J., 1997. Involving traditional healers in AIDS education and counselling in sub-Saharan Africa: a review. *AIDS* 11 Suppl A, S217–225.
- King, S., 2001. *On Writing*. Hachette UK.
- Kleinman, A., 1995. *Writing at the Margin: Discourse Between Anthropology and Medicine*. University of California Press.
- Kuper, H., 1965. *An African aristocracy: rank among the Swazi*. Published for the International African Institute by the Oxford University Press.
- Langa, L., 2010. MCC rubbishes Ubhejane claims. *health-e*.
- Langwick, S., 2008. Articulate(d) bodies: Traditional medicine in a Tanzanian hospital. *American Ethnologist* 35, 428–439.
- Langwick, S.A., 2007. Devils, Parasites, and Fierce Needles: Healing and the Politics of Translation in Southern Tanzania. *Science Technology Human Values* 32, 88–117.
- Leclerc-Madlala, S., 2002. Traditional healers and the fight against HIV/AIDS in South Africa. *Bodies and Politics, Healing rituals in the democratic South Africa* 61–73.
- Lewis, S., 2006. Remarks by Stephen Lewis. In UN Special Envoy for HIV/AIDS in Africa, to the Closing Session of the XVI International AIDS Conference, August (Vol. 18).
- Liddell, C., Barrett, L., Bydawell, M., 2005. Indigenous representations of illness and AIDS in Sub-Saharan Africa. *Social Science & Medicine* 60, 691–700.

- Linn, J.G., 2008. Witches, Westerners, and HIV: AIDS and Cultures of Blame in Africa (review). *Journal of Health Care for the Poor and Underserved* 19, 1008–1010.
- Livingston, J., 2005. *Debility and the Moral Imagination in Botswana*. Indiana University Press.
- Lock, M., Gordon, D., 1988. *Biomedicine Examined*. Springer.
- Luedke, T.J., West, H.G. (Eds.), 2006. *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*. Indiana University Press.
- Madamombe, I., 2006. Traditional healers boost primary health care [WWW Document]. URL <http://www.un.org/africarenewal/magazine/january-2006/traditional-healers-boost-primary-health-care> (accessed 4.10.13).
- Maguire, M., Delahunt, B., 2010. *Practical Step by Step Guide to Thematic Data Analysis*.
- Mail and Guardian, 2011. Sangoma claims Safa owes him R90 000 [WWW Document]. The M&G Online. URL <http://mg.co.za/article/2011-10-11-sangoma-claims-safa-owes-him-r90-000/> (accessed 3.25.13).
- Mall, S., 2005. Attitudes of Health Care Professionals in South Africa to the Use of Traditional Medicine by their Patients on Antiretroviral Treatment: A Research Note. *Social Dynamics* 31, 118–125.
- Marsland, R., 2007. The Modern Traditional Healer: Locating “Hybridity” in Modern Traditional Medicine, Southern Tanzania. *Journal of Southern African Studies* 33, 751–765.
- Marwick, B.A., 1940. *The Swazi: And Ethnographic Account of the Natives of the Swaziland Protectorate*. CUP Archive.
- Mashabane, P., 2012. Enough delays in muti case, declares judge. *The Citizen*.
- Mashile, B., 2011a. Umjindi’s dumbest. *noseweekonline*, Issue 143.
- Mashile, B., 2011b. Good-hearted lawyer steps up. *noseweekonline*, Issue 144.
- Mattingly, C., 1994. The concept of therapeutic “emplotment”. *Social Science & Medicine* 38, 811–822.
- Mattingly, C., 1998. *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*. Cambridge University Press.

- Mckinney, C., 2007. "If I speak English, does it make me less black anyway?" "Race" and English in South African desegregated schools. *English Academy Review* 24, 6–24.
- Mishler, E., 1986. *Research Interviewing: Context and Narrative*. Harvard University Press.
- Mngqundaniso, N., Peltzer, K., 2008. Traditional Healers And Nurses: A Qualitative Study On Their Role On Sexually Transmitted Infections Including Hiv And Aids In Kwazulunatal, South Africa. *African Journal of Traditional, Complementary and Alternative Medicines* 5, 380–386.
- Morris, D.G., Mdlalose, M.B., 2012. The Use of Isihlambezo in the Upper Tugela Region. *South African Family Practice* 12.
- Motlana, N., 1991. Editorial. *Nursing RSA* 6(7).
- Munk, K., 1997. Traditional healers, traditional hospitals and HIV / AIDS: a case study in KwaZulu-Natal. *AIDS Analysis Africa* 7, 10–12.
- Munro, S.A., Lewin, S.A., Smith, H.J., Engel, M.E., Fretheim, A., Volmink, J., 2007. Patient Adherence to Tuberculosis Treatment: A Systematic Review of Qualitative Research. *PLoS Med* 4, e238.
- Myburgh, A.C., 1949. *The Tribes of Barberton District*. Government Printer.
- Myburgh, J., 2007. On medical school 'quotas' [WWW Document]. *Politics Web*. URL <http://www.politicsweb.co.za/politicsweb/view/politicsweb/en/page71619?oid=86906&sn=Detail> (accessed 5.2.13).
- Nattrass, N., 2008. AIDS and the Scientific Governance of Medicine in Post-Apartheid South Africa. *African Affairs* 107, 157–176.
- Neale, J., 2009. *Research methods for health and social care*. Palgrave Macmillan Limited.
- Ngubane, H., 1977. *Body and Mind in Zulu Medicine: An Ethnography of Health and Disease in Nyuswa-Zulu Thought and Practice*. Academic Press.
- Niehaus, I., Jonsson, G., 2005. Dr. Wouter Basson, Americans, and Wild Beasts: Men's Conspiracy Theories of HIV/AIDS in the South African Lowveld. *Medical Anthropology* 24, 179–208.
- Niehaus, I.A., Mohlala, E., Shokane, K., 2001. *Witchcraft, power, and politics: exploring the occult in the South African lowveld*. David Philip ; Pluto Press.

Nyika, A., 2007. Ethical and Regulatory Issues Surrounding African Traditional Medicine in the Context of HIV/AIDS. *Developing World Bioethics* 1, 25–34.

Nyika, A., 2009. The ethics of improving African traditional medical practice: Scientific or African traditional research methods? *Acta Tropica* 112, Supplement 1, S32–S36.

O'Donnell, M.R., Jarand, J., Loveday, M., Padayatchi, N., Zelnick, J., Werner, L., Naidoo, K., Master, I., Osburn, G., Kvasnovsky, C., Shean, K., Pai, M., Van der Walt, M., Horsburgh, C.R., Dheda, K., 2010. High Incidence of Hospital Admissions With Multidrug-Resistant and Extensively Drug-Resistant Tuberculosis Among South African Health Care Workers. *Annals of Internal Medicine* 153, 516–522.

Oosthuizen, S., 2013. R10,7m for botched circumcision. *looklocal*.

Packard, R.M., 1989. White plague, black labor: tuberculosis and the political economy of health and disease in South Africa. University of California Press.

Parsons, T., 1951. Illness and the Role of the Physician: A Sociological Perspective\*. *American Journal of Orthopsychiatry* 21, 452–460.

Patel, V., 1995. Explanatory models of mental illness in sub-Saharan Africa. *Social Science & Medicine* 40, 1291–1298.

Patel, V., Mann, A., 1997. Etic and emic criteria for non-psychotic mental disorder: a study of the CISR and care provider assessment in Harare. *Social Psychiatry and Psychiatric Epidemiology* 32, 84–89.

Patel, V., Musara, T., Butau, T., Maramba, P., Fuyane, S., 1995. Concepts of mental illness and medical pluralism in Harare. *Psychological medicine* 25, 485–493.

Peltzer, K., Mngqundaniso, N., Petros, G., 2006. A Controlled Study of an HIV/AIDS/STI/TB Intervention with Traditional Healers in KwaZulu-Natal, South Africa. *AIDS and Behavior* 10, 683–690.

Pienaar, A., Manaka-Mkwanazi, I., 2004. African Traditional Concepts of Health and Health Care., in: Uys, L.R., Middleton, L. (Eds.), *Mental Health Nursing: A South African Perspective*. Juta and Company Ltd.

Pigg, S.L., 1996. The Credible and the Credulous: The Question of “Villagers’ Beliefs” in Nepal. *Cultural Anthropology* 11, 160–201.

- Polkinghorne, D., 1988. *Narrative Knowing and the Human Sciences*. SUNY Press.
- Popay, J., Williams, G., 1996. Public health research and lay knowledge. *Social Science & Medicine* 42, 759–768.
- Powney, J., Watts, M., 1987. *Interviewing in educational research*. Taylor & Francis.
- Pressfield, S., 2003. *The war of art : break through the blocks and win your inner creative battles*. Warner Books.
- Prior, L., 2003. Belief, knowledge and expertise: the emergence of the lay expert in medical sociology. *Sociology of Health & Illness* 25, 41–57.
- Pronyk, P., Makhubele, M., Hargreaves, J., Tollman, S., Hausler, H., 2001. Assessing health seeking behaviour among tuberculosis patients in rural South Africa. *The International Journal of Tuberculosis and Lung Disease* 5, 619–627.
- Reis, R., 2000. The “wounded healer” as ideology: The work of Ngoma in Swaziland., in: Dijk, R. van, Spierenburg, M. (Eds.), *The Quest for Fruition through Ngoma: Political Aspects of Healing in Southern Africa*. James Currey Publishers, pp. 61–75.
- Rice FL and Ezzy D (2000) *Qualitative Research Methods: A Health Focus*, Oxford University Press
- Robson, C., 1997. *Real World Research: A Resource for Social Scientists and Practitioner-Researchers*. Wiley.
- Rowe, K., Makhubele, B., Hargreaves, J., Porter, J., Hausler, H., Pronyk, P., 2005. Adherence to TB preventive therapy for HIV-positive patients in rural South Africa: implications for antiretroviral delivery in resource-poor settings? *The International Journal of Tuberculosis and Lung Disease* 9, 263–269.
- Rubel, A.J., Garro, L.C., 1992. Social and cultural factors in the successful control of tuberculosis. *Public Health Reports* 107, 626–636.
- Rudwick, S., 2008. “Coconuts” and “oreos”: English-speaking Zulu people in a South African township. *World Englishes*.
- Rycroft, D.K., 1981. *Concise siSwati dictionary: siSwati-English/English-siSwati*. J.L. van Schaik.
- SABC, 2012. Umjindi Municipality to remove residents after illegal occupations. SABC.

- Schulz-Herzenberg, C., 2007. A Lethal Cocktail: Exploring the Impact of Corruption on HIV/AIDS Prevention and Treatment Efforts in South Africa. Institute for Security Studies.
- Shenoi, S.V., Escombe, A.R., Friedland, G., 2010. Transmission of Drug-Susceptible and Drug-Resistant Tuberculosis and the Critical Importance of Airborne Infection Control in the Era of HIV Infection and Highly Active Antiretroviral Therapy Rollouts. *Clinical Infectious Diseases* 50, S231–S237.
- Shuster, J., Sterk, C., Frew, P., del Rio, C., 2009. The Cultural and Community-Level Acceptance of Antiretroviral Therapy (ART) Among Traditional Healers in Eastern Cape, South Africa. *Journal of Community Health* 34, 16–22.
- Sidley, P., 2005. South African foundation is accused of “compromising” care of people with HIV and AIDS. *British Medical Journal* 331, 800–0.
- Siegler, M., Osmond, H., 1973. The “Sick Role” Revisited. *The Hastings Center Studies* 1, 41–58.
- Singh, J.A., Upshur, R., Padayatchi, N., 2007. XDR-TB in South Africa: No Time for Denial or Complacency. *PLoS Med* 4, e50.
- South African Government, 2007. Traditional Health Practitioners act 2007.
- Statistics South Africa, 2011. Census 2011 Municipal Report Mupmalanga.
- Steen, T., Mazonde, G., 1998. Pulmonary tuberculosis in Kweneng District, Botswana: delays in diagnosis in 212 smear-positive patients. *The International Journal of Tuberculosis and Lung Disease* 2, 627–634.
- Steen, T., Mazonde, G., 1999. Ngaka ya setswana, ngaka ya sekgoa or both? Health seeking behaviour in Batswana with pulmonary tuberculosis. *Social Science & Medicine* 48, 163–172.
- Strunk, W., 1958. *The Elements of Style*. Library of Alexandria.
- TAC, 2008. Who are the frauds behind AIDS “cures”? [WWW Document]. URL <http://www.tac.org.za/news/who-are-frauds-behind-aids-cures> (accessed 10.4.13).
- TAC, 2010. Ubhejane is not registered [WWW Document]. Treatment Action Campaign. URL <http://www.tac.org.za/news/ubhejane-not-registered> (accessed 10.4.13).
- Tangwa, G.B., 2007. How Not to Compare Western Scientific Medicine with African Traditional Medicine. *Developing World Bioethics* 7, 41–44.



- Thomas, F., 2007. "Our Families are Killing Us": HIV/AIDS, Witchcraft and Social Tensions in the Caprivi Region, Namibia. *Anthropology & Medicine* 14, 279–291.
- Thornton, R., 2002. Traditional authority and governance in the Emjindini Royal Swazi Chiefdom, Barberton, Mpumalanga: an empirical study. Report submitted to Traditional Authorities Applied Research Network. Calgary, Canada.
- Thornton, R., 2009. The Transmission of Knowledge in South African Traditional Healing. *Africa* 79, 17–34.
- Thwala, S.B., Jones, L.K., Holroyd, E., 2011. Swaziland rural maternal care: Ethnography of the interface of custom and biomedicine. *International Journal of Nursing Practice* 17, 93–101.
- Törün, T., Güngör, G., Özmen, ., Bölükbaşı, Y., Maden, E., Bıçakçı, B., Ataç, G., Sevim, T., Tahaoğlu, K., 2005. Side effects associated with the treatment of multidrug-resistant tuberculosis. *The International Journal of Tuberculosis and Lung Disease* 9, 1373–1377.
- Upvall, M.J., 1992. Nursing perceptions of collaboration with indigenous healers in Swaziland. *International Journal of Nursing Studies* 29, 27–36.
- Van der Geest, S., 1997. Is there a role for traditional medicine in basic health services in Africa? A plea for a community perspective. *Tropical Medicine & International Health* 2, 903–911.
- Van der Geest, S., Finkler, K., 2004. Hospital ethnography: introduction. *Social Science & Medicine* 59, 1995–2001.
- Van Rie, A., Enarson, D., 2006. XDR tuberculosis: an indicator of public-health negligence. *The Lancet* 368, 1554–1556.
- Varga, C.A., Veale, D.J.H., 1997. Isihlambezo: Utilization patterns and potential health effects of pregnancy-related traditional herbal medicine. *Social Science & Medicine* 44, 911–924.
- Veale, D.J.H., Furman, K.I., Oliver, D.W., 1992. South African traditional herbal medicines used during pregnancy and childbirth. *Journal of Ethnopharmacology* 36, 185–191.
- Volmink, J., Garner, P., 1996. Interventions for promoting adherence to tuberculosis management, in: *Cochrane Database of Systematic Reviews*. John Wiley & Sons, Ltd.
- Volmink, J., Matchaba, P., Garner, P., 2000. Directly observed therapy and treatment adherence. *The Lancet* 355, 1345–1350.

Warters, B., 2005. Software Review: Review of TAMS Analyzer (Macintosh Version). *Field Methods* 17, 321–328.

Watson, J., 2005. Traditional healers fight for recognition in South Africa's AIDS crisis. *Nature Medicine* 11, 6–6.

Weingarten, K., 2001. Making sense of illness narratives: Braiding theory, practice and the embodied life, in: White, C. (Ed.), *Working with the Stories of Women's Lives*. Dulwich Centre Publications.

Weinstein, M., 2006. TAMS Analyzer Anthropology as Cultural Critique in a Digital Age. *Social Science Computer Review* 24, 68–77.

WHO, 1995. *Guidelines for Training Traditional Health Practitioners in Primary Health Care*.

WHO, UNICEF, 1978. *Primary Health Care: Report of International Conference on Primary Health Care*, Alma Ata, WHO, Geneva.

Wilkinson, D., Gcabashe, L., Lurie, M., 1999. Traditional healers as tuberculosis treatment supervisors: precedent and potential [Planning and Practice]. *The International Journal of Tuberculosis and Lung Disease* 3, 838–842.

Willcox, M.L., Bodeker, G., 2010. The ethics of improving African traditional medical practice: A response. *Acta Tropica* 115, 163–164.

Wilson, D.M., 2009. *Behind the Scenes in the Transvaal*. BiblioBazaar.

Wreford, J., 2005a. Missing Each Other: Problems and Potential for Collaborative Efforts between Biomedicine and Traditional Healers in South Africa in the Time of AIDS. *Social Dynamics* 31, 55–89.

Wreford, J., 2005b. “Sincedis – We Can Help!” A Literature Review of Current Practice Involving Traditional African Healers in Biomedical HIV/AIDS Interventions in South Africa. *Social Dynamics* 31, 90–117.

Wreford, J.T., 2008. *Working With Spirit: Experiencing Izangoma Healing in Contemporary South Africa*. Berghahn Books.

Zulu, X., 2006. No charges against Ubhejane seller - court [WWW Document]. iol news. URL <http://www.iol.co.za/news/south-africa/no-charges-against-ubhejane-seller-court-1.270171> (accessed 10.4.13).

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## Appendices

### Appendix 1: Respondent Interview Schedule



#### Interview schedule



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Has the participant understood and signed the consent form?

Are there any questions with regards to the participant information sheet?

Go over the confidentiality issue once more so that we clear about my responsibilities, what data I will be collecting

- All data is confidential ☐
- Names will not be used in the final output
- If you consider any line of questioning too sensitive or too personal, you do not have to provide any answers. ☐
- The Interview should last for about 40 minutes to an hour. ☐
- This is not a test, and there are no right answers. It is perfectly ok to say 'I don't know' ☐
- If you feel you want to elaborate on your answers, following this interview, I can be contacted in any number of ways, and as many of you know I have an office in the hospital where I will be spending my time writing up results. Feel free to drop in to discuss any concerns you may have. ☐

Are there any questions thus far?

A brief discussion on terminology.

Time and date of interview:
Number of participant present:
Professional roles of participants:

The participant information sheet you have been given provides some background to the project, but to recap, this is a project studying knowledge, perceptions and attitudes of biomedical professionals - such as yourselves – towards African traditional medicine. Specifically, I am exploring any tensions between biomedicine and ATM. I am interested in exploring your own opinions, but also if it not too sensitive, any personal experiences you may have had as a professional where for example there is an overlap of treatment... one example might be a patient who is using both ATM and Western medicine simultaneously.

Exploring the participant's experience and knowledge of ATM.

I would like to begin by having a general discussion on African traditional medicine. What do the terms '**traditional medicine**' and '**traditional healer**' mean to you?

Explore:

- The role of a traditional healer ...
- Different types of healers...
- Ideas of illness causation...
- Methods of diagnosis...
- Treatment methods...
- Muti – how it is made, and how it is used...
- The process of becoming a traditional healer...
- How widespread traditional medicine use is in the local area?
  - Do they support this observation?
- How would you describe the status of traditional healers?

Comparing and contrasting African traditional medicine and Western biomedicine

Explore: (In the context of previous responses)

compare / contrast:

- the way disease and illness is explained?
- the relationship between the illness / disease, and the 'medicine / muti' used? (Properties of muti / medicine?)
- The way patients are diagnosed?
- The practitioner patient relationship?

Encounters with patients in the hospital / clinic who are using or have recently used traditional medicines

Explore:

- Treatment post ATM
  - How would you know? (Recognition training?)
- Treatment a result of ATM?
  - What symptoms would staff tend to look out for if this is suspected?
- Treatment pre ATM?
  - What about patients expressing a wish to stop treatment to see a traditional healer?
- Treatment alongside ATM?
- ATM interference with allopathic treatment?

Are there defined protocols in the hospital / clinic when dealing with a patients who are using traditional medicines / request to see a traditional healer?

Exploring the participants opinions and attitudes to ATM.

Issues of Collaboration?

Explore

- In what capacity would collaboration be suitable? In the community but not in a hospital / clinic?
- Who would be responsible for the patient and why?
- Where would the lines of authority lie?

## Appendix 2: Participant Consent Form



### Consent to participate – In-depth interviews



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**Project title:**

**Practicing Boundaries:** Exploring how Biomedical practitioners in Barberton understand and navigate African traditional medicine use by patients on TB therapy.

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**By signing below, I agree that:**

1. I have read and understood the Participant Information Sheet. ☐
2. I understand that information provided will be kept in complete confidence. ☐
3. I am fully aware of my rights to:
  - a. My right to withdraw from the study at any point in the study without having to provide an explanation. ☐
  - b. My right to refuse to answer any question put to me without having to provide an explanation. ☐
4. I am taking part in this study voluntarily. ☐

Name of participant (printed) \_\_\_\_\_

Signature of participant \_\_\_\_\_

Name of person obtaining consent: Petros Andreadis \_\_\_\_\_

Signature of person obtaining consent \_\_\_\_\_

### ***Appendix 3: University of Edinburgh Ethical Review***



Centre for Population Health Sciences  
SCHOOL of CLINICAL SCIENCES and COMMUNITY HEALTH

The University of Edinburgh  
Medical School  
Teviot place  
Edinburgh EH8 9AG  
Telephone 0131 650 3248  
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website: [www.chs.med.ed.ac.uk/cphs](http://www.chs.med.ed.ac.uk/cphs)  
email: [p.warner@ed.ac.uk](mailto:p.warner@ed.ac.uk)

7 October 2010

To whom it may concern:

Dear Sir/Madam

**Re: University of Edinburgh internal ethical review of the research project to be undertaken in Barberton Provincial Hospital (South Africa) by Mr Petros Andreadis (PhD student)**

This letter is to confirm that Mr Andreadis' project has been subjected to internal ethical review within the University of Edinburgh, and that it has been judged to meet all requirements for due ethical process.

Mr Andreadis has submitted his protocol and a completed ethics form to the Ethical Review Group of our Centre for Population Health Sciences, and this material has been reviewed by two senior members of staff (an experienced qualitative researcher and myself), who have judged that the research proposed presents no ethical concerns.

Our Centre is very grateful to the University of the Witwatersrand and Mpumalanga provincial Department of Health (in particular Barberton Hospital) for the part they are playing in enabling this research to be undertaken.

Yours faithfully

PE Warner

Dr Petros Andreadis

**Appendix 4: University of the Witwatersrand Ethical Review**

**UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG**

Division of the Deputy Registrar (Research)

**HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)**

R14/49 Andreadis

**CLEARANCE CERTIFICATE**

**PROTOCOL NUMBER H100 925**

**PROJECT**

Boundaries of treatment: exploring how biomedical practitioners in Barberton understand and navigate African traditional medicine use by patients on TB therapy

**INVESTIGATORS**

Mr PI Andreadis

**DEPARTMENT**

Anthropology

**DATE CONSIDERED**

17.09.2010

**DECISION OF THE COMMITTEE\***

Approved Unconditionally

**NOTE:**

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

**DATE** 08.10.2010

**CHAIRPERSON**

  
(Professor R. Thornton)

cc: Supervisor: Ms SC Burley /Prof R Thornton

**DECLARATION OF INVESTIGATOR(S)**

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. I agree to a completion of a yearly progress report.

  
Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES



## Appendix 5: Mpumalanga Department of Health Study Approval

### MPUMALANGA PROVINCIAL GOVERNMENT

Building No.3  
No. 7 Government Boulevard  
Riverside Park Extension 2  
Nelspruit  
1200  
Republic of South Africa



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### Department of Health

Litiko Lcetemphilo

Umntyango WezaMaphilo

Departement van Gesondheid

Enquiries: Kate Mathe 3102

01 November 2010

Mr Petros Isidoros Andreadis  
School of Public Health Science  
2nd Floor  
University of Edinburgh Medical School  
Teviot Place  
EH 8 9AG  
Dear Mr Petros Isidoros Andreadis

#### APPLICATION FOR RESEARCH & ETHICS APPROVAL: A STUDY EXPLORING METHODS AND EPISTEMOLOGY IN RELATION TO TENSIONS ARISING FROM MEDICAL PLURALISM.

The Provincial Research and Ethics Committee has approved your research proposal in the latest format that you sent. No issues of ethical consideration were identified.

Kindly ensure that you provide us with the report once your research has been completed.

Kind regards,

Molefe Machaba  
Acting Director: Planning, Information & Research

01-11-2010  
Date





